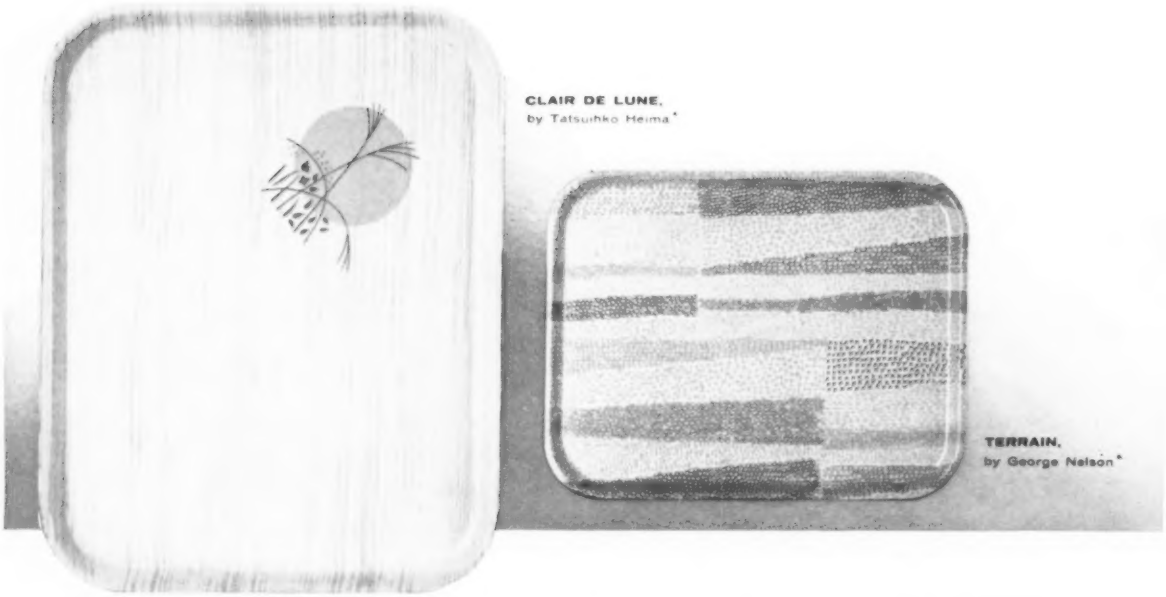
The Modern Hospital

JULY 1957

ENTRANCE TO GROSSMONT DISTRICT HOSPITAL, LA MESA, CALIF. (Page 55)



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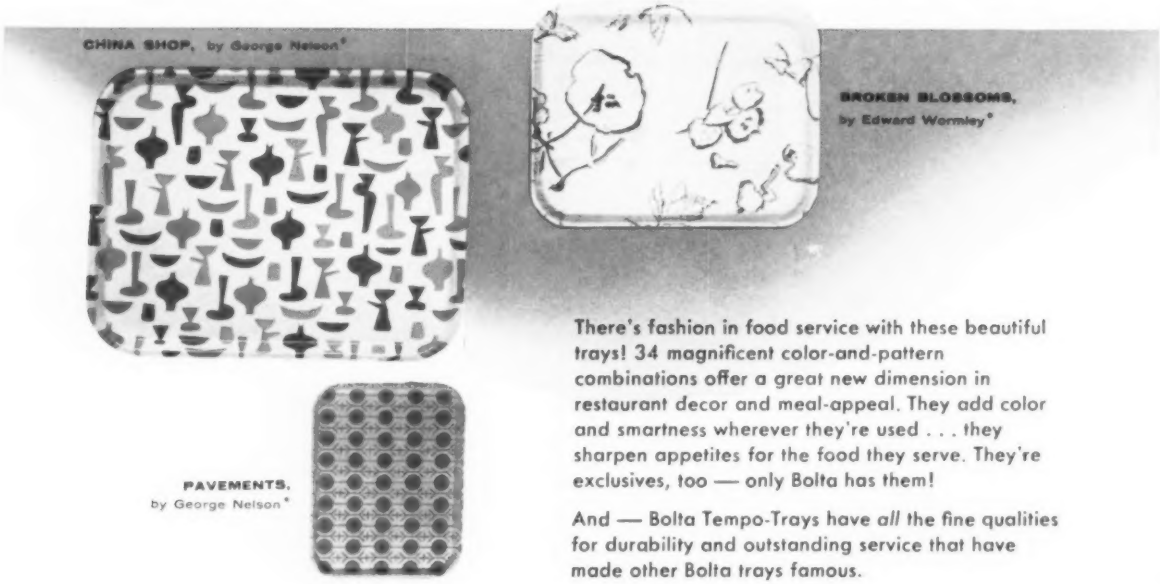

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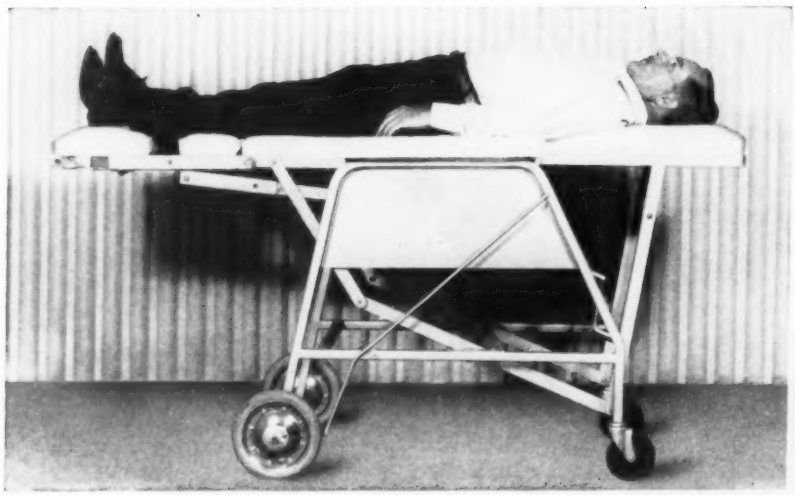

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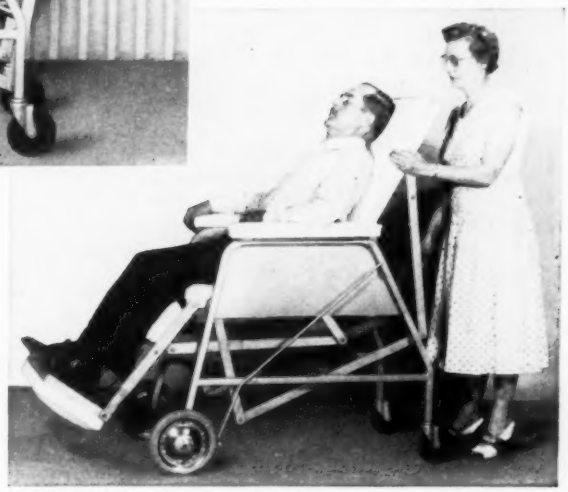

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JULY 1957

VOLUME 89, NO. 1

ADMINISTRATION

SMALL HOSPITAL FORUM

MEDICINE AND PHARMACY

FOOD AND FOOD SERVICE

MAINTENANCE AND OPERATION

HOUSEKEEPING

REGULAR FEATURES

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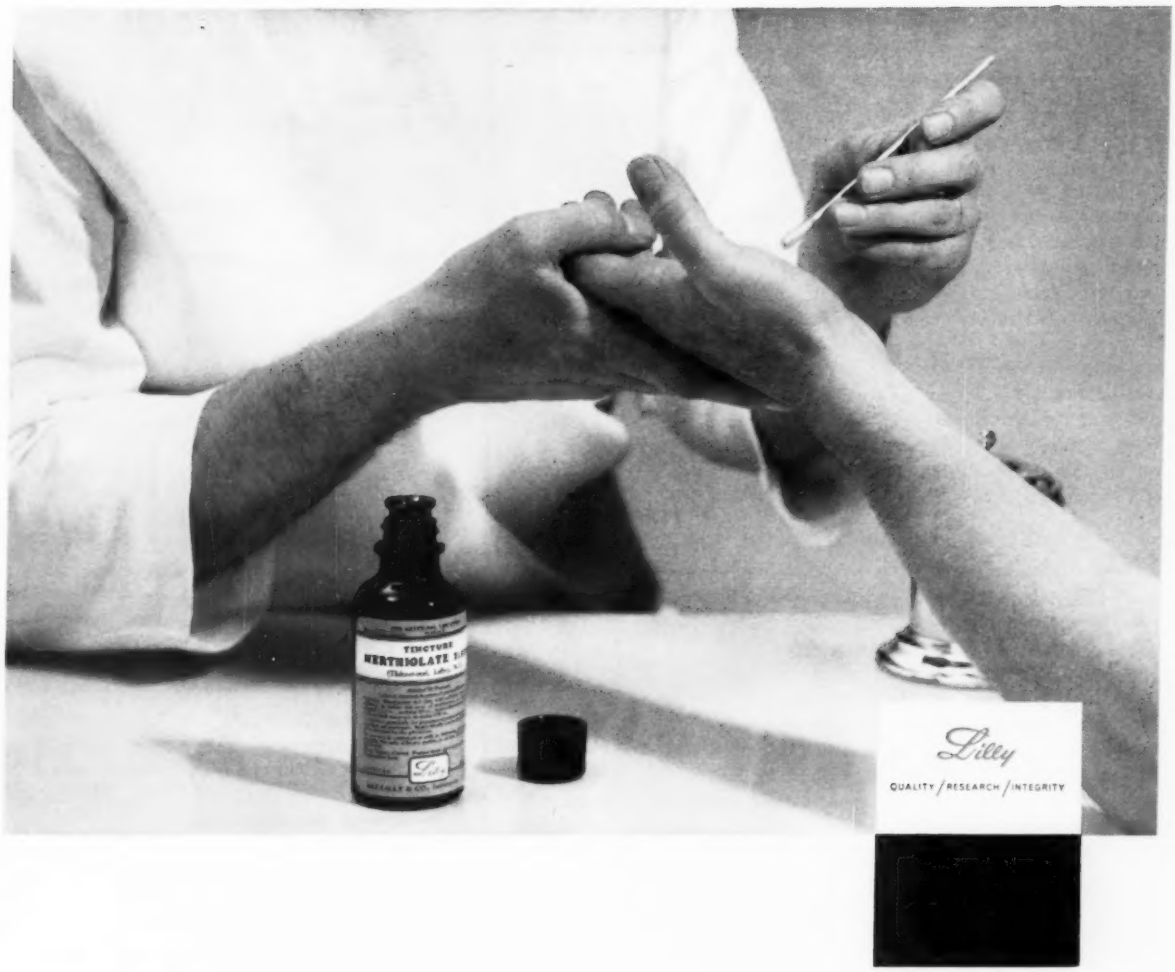

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AMONG THE AUTHORS


John H. Holmgren

A three-part study of procedures essential to establishing salary rates for hospital employes begins in this issue on page 63. **John H. Holmgren** has held administrative and personnel positions in industry, education and government for the last 14 years. In 1950 he completed a statewide personnel survey for the Hospitals of the Sisters of St. Joseph. He now is a full-time business administrator for the Sisters, assisting in over-all administration of their 12 hospitals located in three states, and works directly in the operation of Wichita-St. Joseph Hospital, Wichita, Kan. Mr. Holmgren is a graduate of Northwestern University and did graduate work in administration at the University of Chicago.


Robert P. Lawton

Food service business is big business, a fact many hospitals don't appreciate, says **Robert P. Lawton** on page 106. Mr. Lawton, administrator of Danbury Hospital, Danbury, Conn., has found that a hospital's kitchen often is busier than that of any restaurant in the same community, and, as a result, the dietitian must use businesslike methods of buying, storing, preparing and serving food. He discusses some aids to efficiency, including a food service control sheet, standardized portions and serving utensils, and labor saving machines. A graduate of the University of Vermont, Mr. Lawton entered the hospital field in 1946, after several years in the casualty insurance business and three years as a navy supply and provisions officer. He was assistant administrator of Mary Fletcher Hospital, Burlington, Vt., before becoming administrator of the Danbury Hospital in 1954.


Charles R. Gage

Fire safety technics did some fast traveling during May, as Lt. Robert A. McGrath, hospital inspector in the Fire Prevention Bureau of the Chicago Fire Department, conducted a six-day series of Disaster Planning Institutes in six Louisiana cities. On page 77, **Charles R. Gage** describes what happened when the lieutenant and he, together with officials of the Louisiana Hospital Association, took to the road. Mr. Gage has been executive secretary and treasurer of the association since October 1956 and is the first person to hold this position on a full-time basis. Prior to assuming his present position, he was director of personnel and public relations for Southern Baptist Hospital, New Orleans.

Problems of providing both good nursing care and an adequate amount of nursing care for patients face every hospital administrator. On page 71, **Dr. Thomas Hale Jr.**, administrator of Albany Hospital, Albany, N.Y., discusses these problems as they concern the nurse, nurse educator, patient, physician and hospital administrator. Dr. Hale looks at the situation not only with the eyes of an administrator: He also is associate dean of Albany Medical College; a former practicing surgeon in what he terms the "wilds" of northern New Mexico, and the father of two young ladies he hopes will some day adopt nursing as their profession.

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READER OPINION

Shortage of Technicians

Sirs:

The problem of the future shortage of technicians concerns me. This was brought more forcibly to my attention when I accompanied the recruiting film for the field of medical technology, sponsored by the ASCP, to various high schools, where it was shown to scientifically inclined high school students. These high school students, who apparently are already aware of the facts of life, were highly amused when I had to admit what the salaries are for medical technicians in this area.

At present, I am paying my medical technicians $350 per month for a 40 hour week. For this pay, they are expected to take their turns on Saturday and Sunday, with a compensatory day off. On a 40 hour week, this figures out to $2.02 per hour. I am ashamed of this wage, since most of them are college graduates. If they had taken another field of science such as engineering, instead of medical technology, in college, their starting salaries would be $100 to $200 per month higher.

It is interesting to me to note that even common laborers today receive $2.30 per hour, with time and a half for overtime. This is $0.28 an hour more than my college graduate technicians are making.

Since I believe even the best medical laboratory is no better than its poorest technician, and that, if something isn't done to raise the technicians' salaries, we are going to get technicians of lower and lower caliber, I am planning, in the near future, to raise all of my technicians' salaries to an equivalent of at least $2.50 per hour, or $400 for each four-week pay period.

The head of the department in San Diego State College who guides the prelaboratory technician students has stated that the number of college students taking prelaboratory technician courses is dwindling rapidly, and many of these students are switching their courses to teaching. In her opinion, the only cure for this dwindling of the supplies of prelaboratory technicians is to raise salaries to *at least* the equivalent of teachers' salaries.

Recently the San Diego Hospital Council commissioned Vivian Hammon to tour the United States, in an attempt to recruit hospital personnel for the San Diego hospitals. Five of the hospitals requested the recruiting of medical laboratory technicians.

She returned with a discouraging report regarding the present and the future supply of medical laboratory technicians. She was in approximately 15 university centers throughout the United States, and everywhere she received the same report. Few, if any, students are now entering prelaboratory technician courses in colleges and universities. The placement offices in these universities are no longer attempting to place laboratory technicians, as the demand is so much greater than the supply that there is no further need for placement office systems in obtaining jobs for the graduating technicians.

Miss Hammon found that many pharmaceutical houses are now sending representatives to the colleges, to try to get sophomore and junior stu-

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dents to terminate their education immediately and enter the pharmaceutical companies at salaries higher than technicians can expect if they complete their college education.

She was told by more than one source that the hope of recruiting people into the field of medical technology must be from middle aged women who have already raised their families, or who have their families in school, and would like to enter the profession as a means of adding a second income to the family.

With the new state law which went into effect on January 1, one of our other sources of laboratory technicians was cut off, namely, the navy technicians, almost all of whom have had no college training. I personally was using three navy technicians, all of whom I had let go as of January 1.

This laboratory is qualified by the state of California to have a laboratory training school. If an attempt were made to take in *several* student technicians, to ease my own personal technician shortage, the result would be that I would be competing with the existing schools for a rapidly dwindling number of prospective students, and this would not solve the problem of the general technician shortage.

H. R. Irwin, M.D.
Pathologist
Sumerlin Memorial Laboratory
Donald N. Sharp Memorial
Community Hospital
San Diego, Calif.

Economics of Chronic Disease

Sirs:

I was interested in the Reader Opinion comment in the April issue of The MODERN HOSPITAL by Morris Bernstein re the chronic unit at Maimonides at San Francisco.

I am wondering if the principal unfavorable economic factors which may affect such units—in the case of occupancy, at least, by patients in modest circumstances—may run something like this:

(1) Lack of sufficient background of preoperative experience; (2) services to the patients on a scale too elaborate and too expensive; (3) facilities over-capitalized from the standpoint of capital costs, and (4) an unrealistic attitude in the United States which has grown re "our health" which, like Humpty Dumpty, may have a certain experience—but when?

George Blumenauer III
Architect
Kansas City, Mo.

Why No Medical Library?

Sirs:

The Modern Hospital of the Month for May 1957 [Morristown-Hamblen Hospital, Morristown, Tenn.], has no medical library and the administrator doesn't even miss it?

Kathleen Dooley
Librarian
Kenmore Mercy Hospital
Kenmore, N.Y.

Administrator Tells Why

Sirs:

We were aware of the fact that no provisions were made for a medical library but we installed the library as a part of the doctors' lounge and have a fairly complete medical reference library.

W. G. Messer
Administrator
Morristown-Hamblen Hospital
Morristown, Tenn.

ROVING REPORTER

East Meets West in Hospital

A hospital is the biggest building in Qatar, an independent state of 4000 square miles on the Arabian side of the Persian Gulf, and it's also the first large steel framed building ever constructed in Doha, the country's capital city.

From the time of the hospital's conception in 1952 by His Highness Sheikh Ali Bin Abdullah Bin Jasim Al-Thani, ruler of Qatar, until its completion in February 1957, the builders faced a multitude of problems.

Erecting a steel framed structure in a country that was without most materials required for structural work, located far from the supplies of most manufactured materials, and lacking in skilled construction workers seemed a nearly impossible task. The concrete was made of carefully selected local materials.

Temperatures of 118°F. in the shade, plus considerable humidity, added to the difficulties. Expansion and contraction of the building as a result of variations in atmospheric temperatures constituted a major problem. Because the hospital was, in essence, a continuous structure, it was necessary to provide expansion joints at convenient positions to divide the building into separate units. These expansion joints were formed at maximum intervals of 100 feet by use of two steel frames, one on either side of the expansion joint, each supporting the building on its respective side and giving a 1 inch separation between units.

The variation between the temperature of the outer skin of the external walls and the average temperature within called for some means of allowing the outer skin to expand and contract. Vertical expansion gaps through the outer leaf walls, at 21 foot centers, left the top of the wall free from the beam casing to enable it to move. Special fixings were designed to stabilize the blockwork and yet give it freedom to move.

All steel work had to be designed and fabricated in England, given a trial erection, and then shipped to the construction site.

The hospital was built on rock, which has poor conductivity. Earth electrodes for lightning protection were sunk by a rig to the water table, at an average depth of 55 feet.

Main entrance of the state hospital in Doha, Qatar. Steel work was fabricated in England, shipped to site.

A cosmopolitan approach helped to solve the skilled labor problem. The architect, John R. Harris of London, England, was selected by an open competition that attracted 335 architects from Australia, Japan, South Africa, Sweden, England, India, Ceylon, Ethiopia and China and resulted in 74 designs finally submitted and judged. Technicians from 14 countries were employed during the actual construction work.

The main units of the hospital are confined to two stories to reduce the need for elevators in case of emergency. However, the frame and foundations were designed to be extended at a later date to form two complete additional ward units. The air conditioning system also can be extended.

All wards face north toward the sea and the prevailing breeze. Verandas for single bed rooms face east or west; the wards are pleasantly lighted from the verandas. This unique plan has enabled the wards to be more compactly planned than would normally be possible. Some roofs are paved for the use of ambulatory patients and the staff, with the stairs serving both as access and as fire escapes.

For reasons of Purdah, male patients are housed on the ground floor, and women on the first floor.

The area near the hospital contains 11 senior houses, four self-contained apartments, 12 apartments for sisters, and quarters for 56 nurses, in addition to residential dining blocks and servants' quarters.

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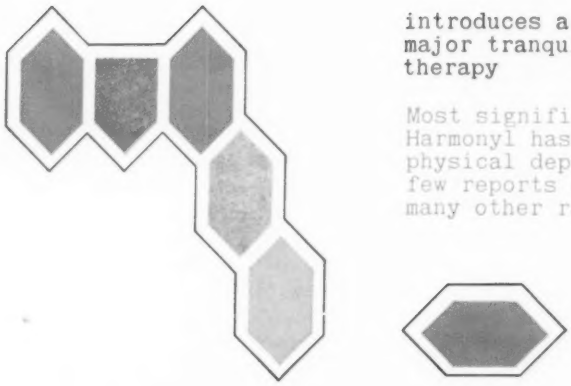

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Safety—plus marked clinical effectiveness

Harmonyl proved particularly effective, for example, in tranquilizing a group of 40 chronically ill, agitated senile patients.[1]

Of particular interest is the observation that patients became more lucid and alert on Harmonyl therapy. And there was a complete absence of side effects with Harmonyl—although a similar group on reserpine developed such side effects as anorexia, headache, bizarre dreams, shakes, nausea and vomiting.

Following another eight-month study of chronic, hospitalized mental patients, Ferguson[2] stated:

- Harmonyl benefited at least 15% more overactive patients and proved more potent in controlling aggression—requiring only one-half to two-thirds the dosage of reserpine.

- Patients experiencing side reactions on reserpine often were completely relieved when changed to Harmonyl.

Ferguson concluded: "The most notable impressions were the absence of side effects and relatively rapid onset of action with Harmonyl."

Comparative studies have shown Harmonyl and reserpine about equal in hypotensive effect. The tranquilizing action of the two drugs also appeared similar—except that few cases of giddiness, vertigo, sense of detached existence or disturbed sleep were seen with Harmonyl.

Professional literature with complete information is available upon request. Harmonyl is supplied in 0.1-mg., 0.25-mg., and 1-mg. tablets.

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References: 1. Communication to Abbott Laboratories, 1956. 2. Ferguson, J. T.: Comparison of Reserpine and Harmonyl in Psychiatric Patients: A Preliminary Report, Journal Lancet, 76:389, December 1956.

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The Trustee Is Neglected Until Things Go Wrong

By GORDON DAVIS

Gordon Davis

OUR considered nomination for the title of "World's Most Neglected Person" is the hospital trustee. He serves the public sturdily, but the public doesn't know he exists.

The trustee is disregarded, that is, until something happens to go wrong. Let there be a real or fancied failure in the hospital and there is no end to the indignation visited upon the same selfless person who has sacrificed time, money and pleasure to render a clear public service.

Every trustee who has had his friends take him to task for hospital costs has felt the sting of this paradox.

On the other hand, trustees as a group often invite such treatment. Many are reluctant to see themselves publicized, and there is much that is commendable in their restraint. But it is not very realistic.

For years there has been ample evidence that the days of anonymous trusteeship are at an end. The evidence has ranged from the government's antitrust suits to the rousing battles for control of such corporate titans as the New York Central and Montgomery Ward. It is the directors, not the managers, who are thrown on the griddle in these fracases.

A hospital is not a commercial corporation, but its public responsibility is all the broader thereby. Moreover, the hospitals are sorely in need of greater public understanding, and no one can understand a hospital who does not understand the character, the functions and the integrity of its board of trustees.

Because there is little or no effort to promote this general understanding, a great source of public confidence in hospitals is being almost wholly ignored.

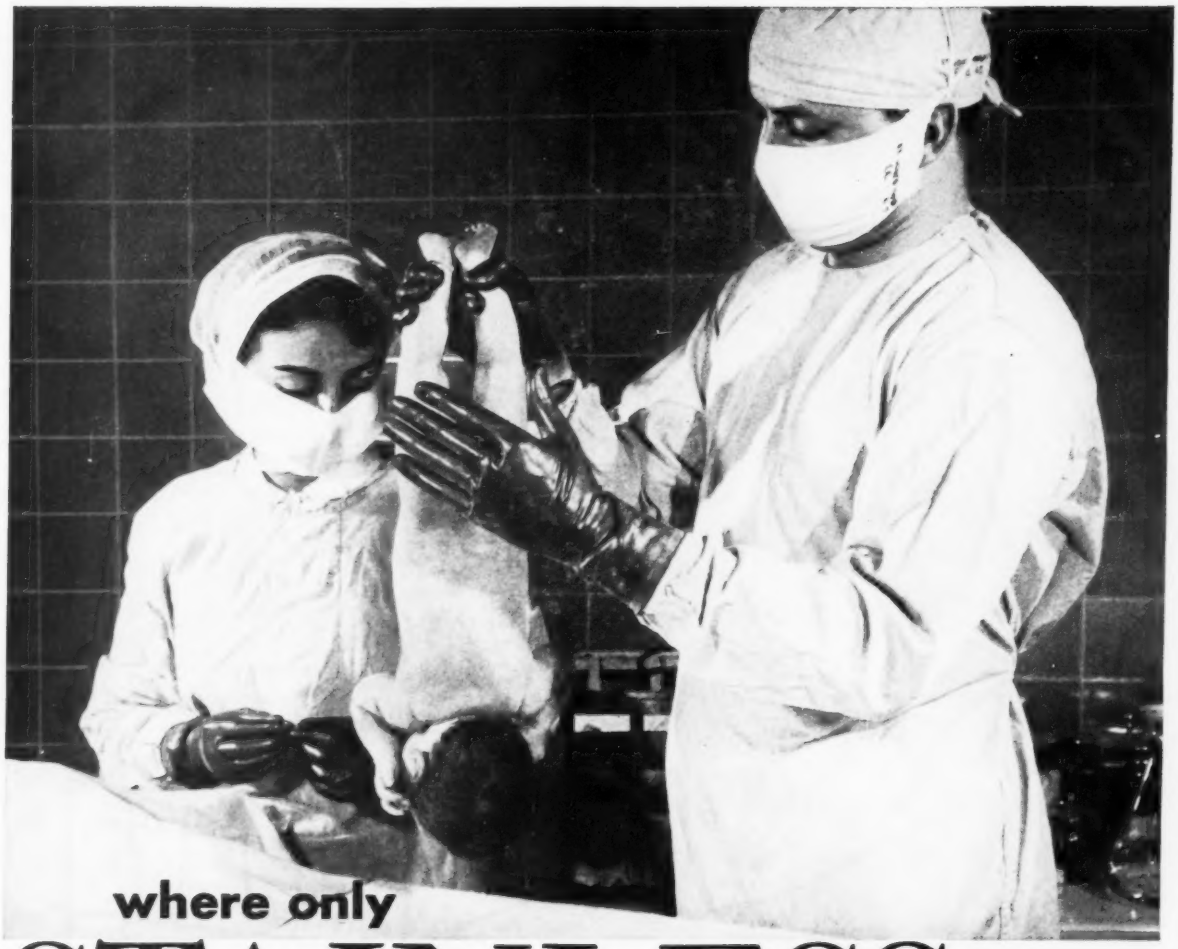
The failure is not peculiar to hospitals or to hospital boards, however. Most of our health professions and institutions habitually neglect to reap the public good will inherent in what might be called their collateral public service activities.

The medical profession, for example, has made no consistent effort to tell the public about the unremunerated services by medical men in charity clinics, in medical classrooms, in consultation with community health agencies. Here, there is often good reason for avoidance of individual publicity, but the total story is one that should be told regularly, dramatically and with pride.

And, to return to the hospitals, the people generally have little understanding of hospital educational functions and the services of hospitals as focal points for many community health activities ranging far beyond bed care.

The people have a right to an understanding of these things. The hospitals and the health professions have a right to the appreciation and support that come with understanding.

More significantly, the hospitals and the health professions exist to serve. Their service cannot realize its full potentials in the presence of ignorance or misunderstanding on the part of those whom it is intended to benefit.



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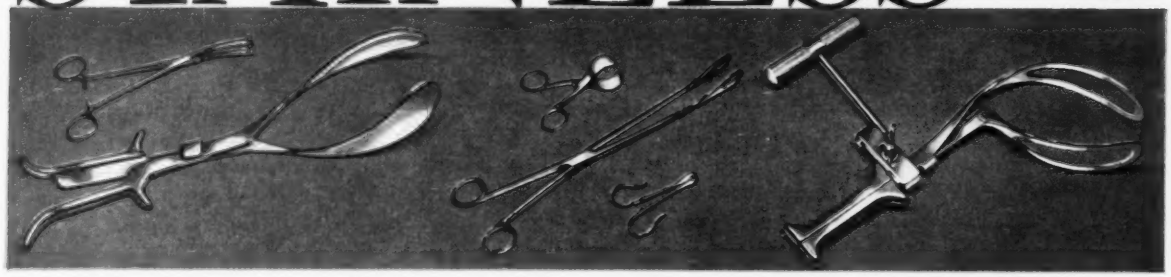

In the Delivery Room, the Operating Room, wherever life and death are the stakes, *stainless* steel is the only metal good enough to play a part.

For instruments, operating tables, trays—even in the hospital kitchen and laundry—*stainless* means rigid cleanliness, efficiency and dependability.

The fact is, *stainless* is *essential* for many hospital tasks—in others it is the most *practical* of metals. *Crucible Steel Company of America, The Oliver Building, Mellon Square, Pittsburgh 22, Pa.*

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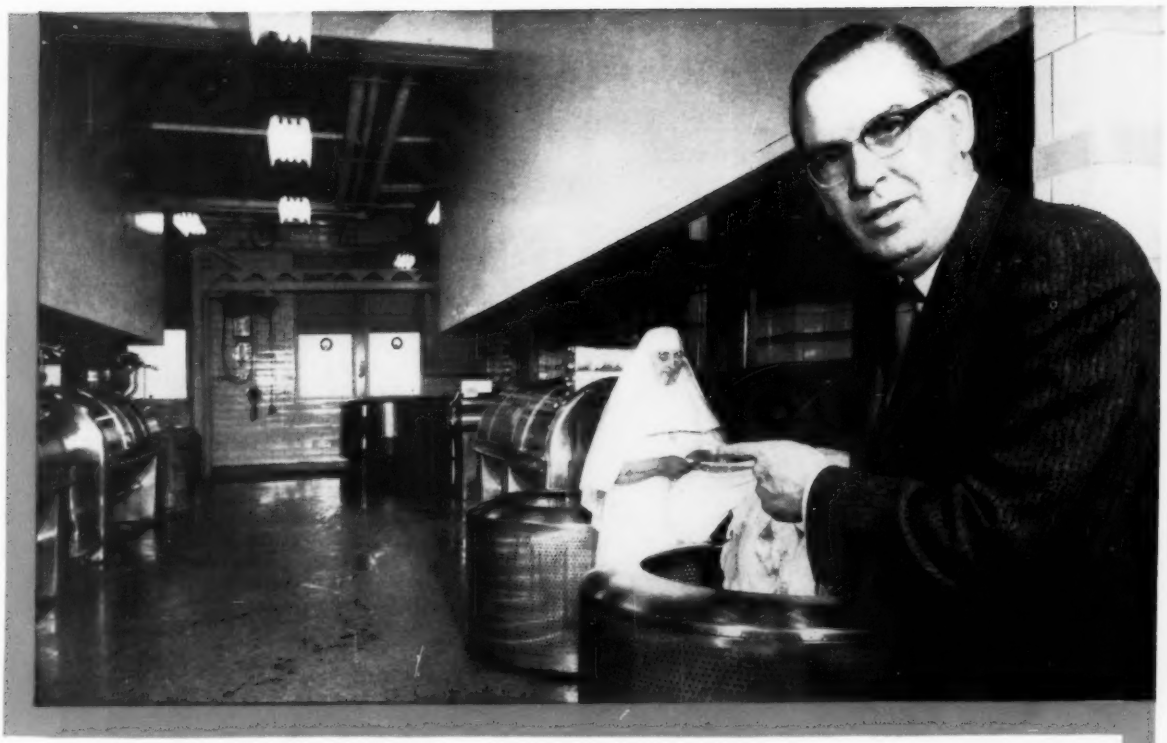

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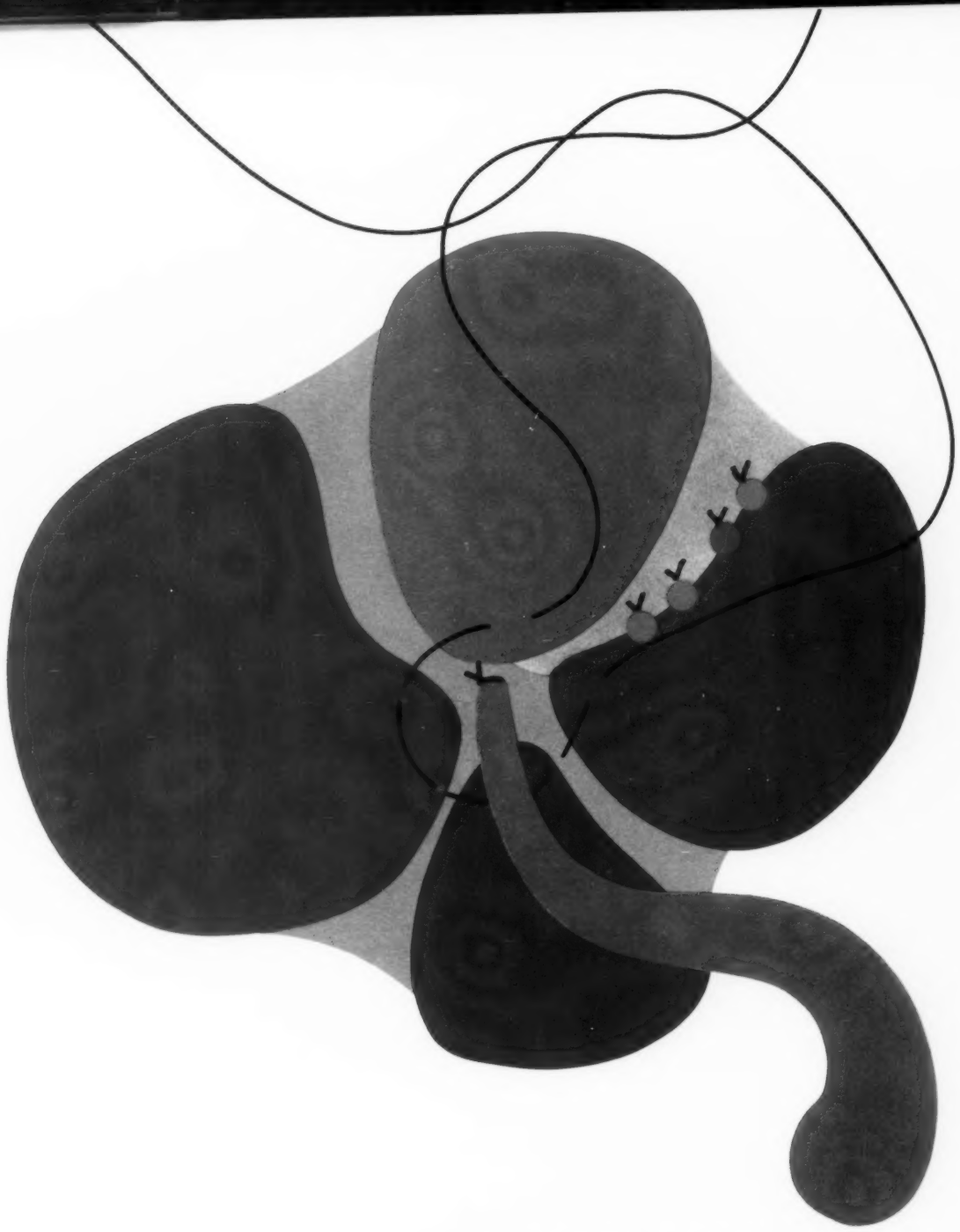

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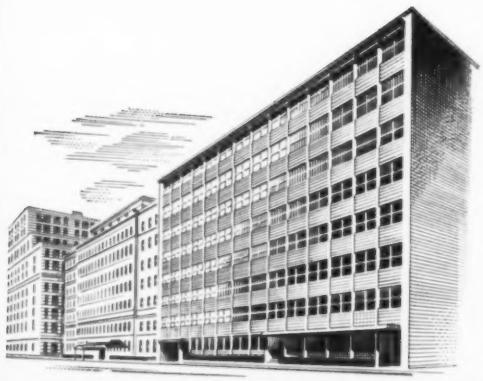


How Mt. Sinai Hospital gains nursing time, cuts foot travel, speeds all services!

AUDIO-VISUAL NURSE CALL SYSTEM. At Mt. Sinai, Executone's two-way voice communication between patient and nurse cuts nurse's foot travel more than 60%...allows nurse more time for actual patient care.

New York's famed Mt. Sinai Hospital has pioneered in the application of electronic voice communication. Starting 14 years ago with its first Executone Intercom System in the Radiology Department, Mt. Sinai quickly extended the use of this modern time-saving equipment.

Today, Executone is an integral part of Mt. Sinai, serving the entire hospital. With 325 beds already served by Executone's Audio-Visual Nurse Call System, Mt. Sinai has applied other Executone intercom and sound systems to its many services and departments. Thousands of needless steps are saved daily at Mt. Sinai with Executone—clear, distinct two-way conversations take place at the touch of a button. The over-all result is more personalized patient care and improved administrative efficiency.

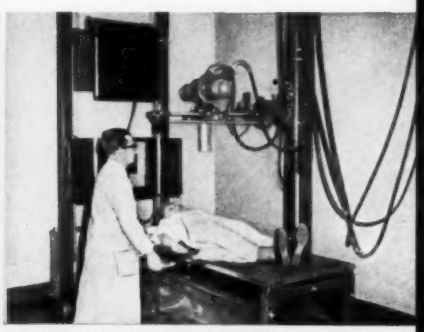
Hospitals throughout the nation have discovered the effectiveness, economy and complete dependability of Executone for *all* services. Executone's Audio-Visual Nurse Call System alone is now serving over 12,000 hospital beds. Find out—*without any obligation*—how Executone can work for you as it does for Mt. Sinai and the entire hospital field. Write to Dept. Z-4 for further information: Executone, Inc., 415 Lexington Avenue, New York 17, N. Y. (In Canada—331 Bartlett Avenue, Toronto.)

Executone

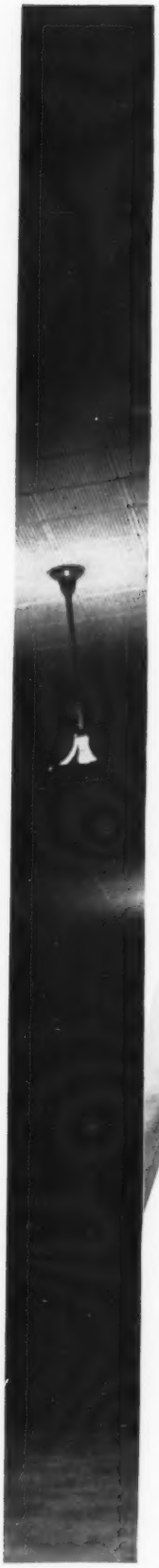
HOSPITAL COMMUNICATION SYSTEMS

NON-CORRIDOR PAGING. Doctors' paging calls at Mt. Sinai are reproduced at Nurses' Stations—not in Patient Corridors. (Arrow indicates paging unit.)

CENTRAL KITCHEN COORDINATION. An average of 6600 meals are served daily. Executone speeds activities with communication between Steward, Dietician, Food Preparation and Serving areas.



RADIOLOGY TRAFFIC CONTROL. Handling of patients coordinated through Executone between technicians, Reception area, Dark room, Film Files, and Chief Radiologist.



Lessen the Nursing Burden with Honeywell Bedside Temperature Control

Provide better therapy . . . more comfort for your patients

DEMANDS on nurses' time are lessened when patients can make their own room temperature adjustments with a *Honeywell Bedside Temperature Control*. Patients make themselves comfortable and your nurses are freed from many time-consuming tasks. You know these all too well—opening and closing windows, carrying blankets and refilling hot water bottles.

With the "bedside" installation of the new Honeywell Round mounted for finger-tip adjustment, the patient can control room heating and ventilation as easily as reaching for a call button. In two-bed rooms the Honeywell Round can be mounted between the beds.

In addition, Bedside Temperature Control provides a saving in fuel costs by eliminating heating waste. It allows physicians and surgeons to "prescribe" exact room temperatures to help speed patient recovery.

Specify Honeywell Bedside Temperature Control for your new hospital or addition. Also available for your existing bedrooms at costs as low as $87.50 per room*. No tearing out of walls or redecorating is necessary. For more information, call your local Honeywell office now. Or, write Minneapolis-Honeywell, Dept. MH-7-81, 2727—4th Avenue, South, Minneapolis 8, Minnesota.

**Average installed price for room with one radiator*

Honeywell

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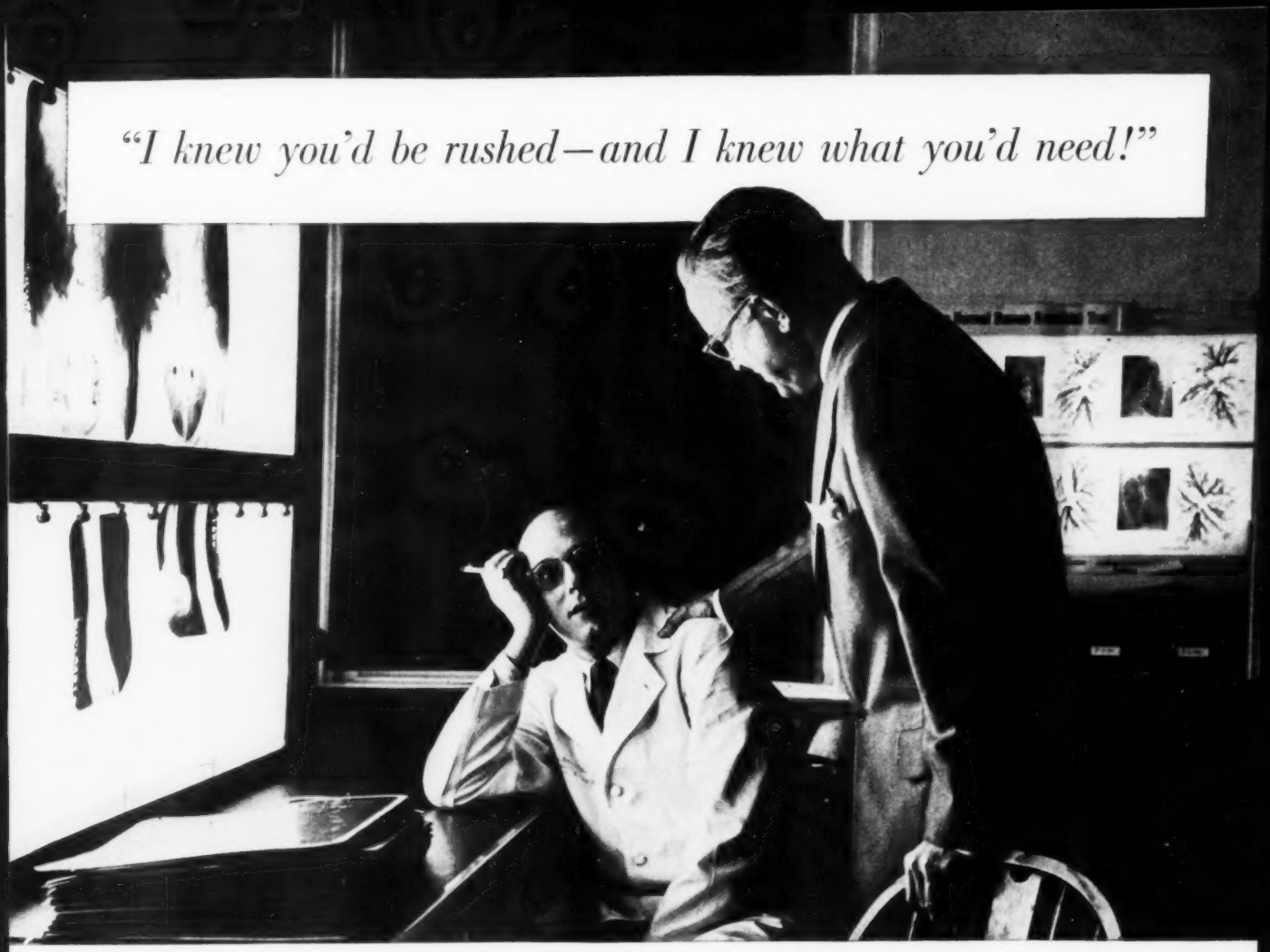

The pressure is on in X-ray. Never before have they handled so many patients – yet things are running smoothly. And there's not a hitch in sight.

Fact is, the radiologist never even had a chance to call for help. The administrator saw the rush coming – and beat him to the punch!

How? From his monthly reports the administrator was able to evaluate the coming situation – *before* it actually arrived. Figure facts on the utilization of special services by incidence of stay by kinds of patients alerted him to the changes taking place. And with this information at his command, he adjusted his budget *in time* to provide added help and facilities to meet the mounting demand on X-ray's services.

This is but one example of how proper figure facts can point up situations that demand administrative action. For further evidence, write to us today for your complimentary copy of "Better Patient Care Through Administrative Controls."*

**A paper delivered by John L. Mayer, Jr., at an A.A.H.A. conference, Orlando, Florida*

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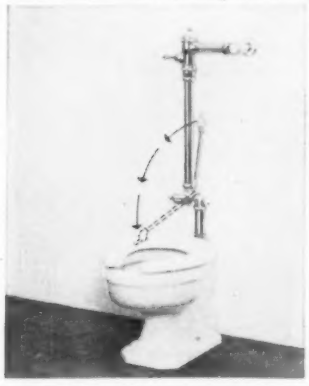
Hoseless BEDPAN RINSER

EASY TO INSTALL

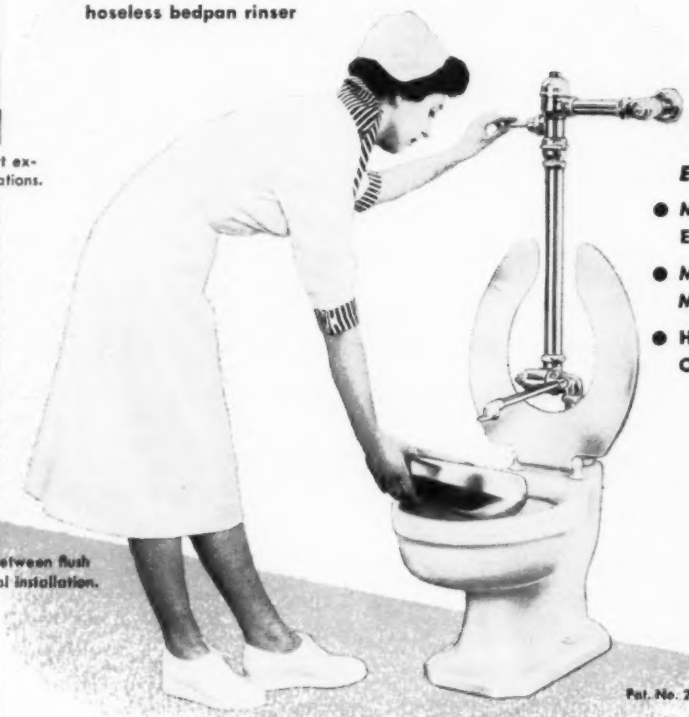
Existing flush valve raised to permit short extensions on either new or existing installations.

American-Gray Diverter Valve placed between flush valve vacuum and toilet. Easy economical installation.



Top, back and side inlets can be accommodated with complete piping between vacuum breaker and toilet.

American-Gray Diverter Valve installed and convenient to use as a hoseless bedpan rinser



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- **MINIMUM MAINTENANCE**
- **HOSELESS OPERATION**

Nursing personnel welcome the ease and convenience of the American-Gray Diverter Valve. Cost-conscious administrators like its simple, low-cost installation, minimum maintenance and time saving. Acceptable under the most rigid plumbing codes, thousands of American-Gray Diverter Valves are saving hours and dollars in Hospitals and Nursing Homes throughout the world.

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The miracle moist Towelette!

WASHES HANDS AND FACE
WITHOUT WATER, SOAP, TOWEL

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SAVE THOUSANDS OF DOLLARS IN EXPENSIVE BEDSIDE CARE

Sealed, saturated Wash 'n Dri tissues save nursing time—cleanse, cool, soothe patients.

1. Hermetically sealed, saturated, antiseptic tissues for bedside use and patients' meal trays.

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3. Easy to open, no towel needed, air-dries in seconds, leaves skin smooth, soft clean.

4. Useful for bathing children during fever, cooling and comforting patients after surgery, childbirth, and dental extractions.

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The Berkshire Eagle—April 9
PITTSFIELD, MASS.

Wash Tissues Given Trial At St. Luke's

Wash basins, water pitchers, soap, washcloths and hand towels have been replaced at St. Luke's Hospital by matchbook-sized alcohol-dampened tissues.

Sister Superior Marie Reparatrice, hospital administrator, said the tissues, known as Wash 'n Dri, are being used both as a time-saver for hospital employes and as a convenience for the patients.

Packed in aluminum foil, the towelettes are easily unfolded to 6 by 8 inch size. The alcohol solution cleans, cools, refreshes and dries by evaporation.

Patients get their daily bath in the usual way, but they much prefer Wash 'n Dri for the early morning washup, after meals, after reading newspapers and whenever they want to feel clean and cool, the administrator said.

"In addition to saving countless nursing hours, the patients are happier with the new service," Sister Superior said. St. Luke's is one of the first hospitals in the country to adopt the system.

Wash 'n Dri is made by R. R. Williams Inc. of Canaan, Conn. The towelettes are particularly handy in water shortages and other emergencies.

ONLY HIGH STEAM TEMPERATURES can bring out these distinctive markings on "SCOTCH" Hospital Autoclave Tape No. 222.

YOU'RE ALWAYS SURE...

with "SCOTCH" Hospital Autoclave Tape No. 222

LEAVES NO STAINS or gummy residue! "SCOTCH" Hospital Autoclave Tape No. 222 is the only tape that holds firmly in high steam temperatures, yet peels off neatly without discoloring linens. It seals packs in half the time required for pinning, tying or tucking, takes pencil or ink markings.

NO CHANCE OF ACCIDENTAL ACTIVATION of this tape – radiator heat or sunlight doesn't affect the special inks used in "SCOTCH" Hospital Autoclave Tape No. 222. It takes the sustained high steam temperatures of the autoclave to make those distinctive diagonal markings visible – and you can see them clear across the room! *This is not positive proof of sterility, of course – nothing on the outside of a bundle can prove that.*

See your surgical supply dealer now for "SCOTCH" Hospital Autoclave Tape No. 222 and new tape-saving dispensers!

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Disposable Unit

ready-to-use with pre-lubricated rectal tube and "personalized" carton

When the FLEET ENEMA Disposable Unit replaces old-fashioned enema equipment, personnel are released for other duties.*

FLEET ENEMA Disposable Unit is *safe* to use . . . the anatomically correct rectal tube minimizes injury hazard. FLEET ENEMA is *easy* to use . . . plastic squeeze bottle permits the "infinite ease of the one hand squeeze." Each FLEET Disposable Unit contains an enema solution of Phospho-Soda (Fleet) . . . gentle, prompt and *more effective* than one or two pints of soap suds or tap water.(1)

**"It is possible to give seven enemas with the Fleet Disposable Unit in the time required to administer one soapsuds enema."*

Standard vs Disposable Unit Enema: Rainier, W. G. and Lee, B., Hospitals, 31:50, January 1, 1957.

(1) Swinton, N.W., Surg. Clin. No. Am., 35:833, 1955

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Another Hill-Rom First — series 8,000 hospital furniture

color styled by Howard Ketcham

Hill-Rom
Contemporary
FURNITURE FOR THE MODERN HOSPITAL

• This beautiful private room grouping is a happy combination of the traditional and the modern in hospital furniture design and finish. A distinctive feature is the decorative line which curves gracefully across the panel parts to contrast pleasingly with the deep, luxurious finish of the wood as fashioned by our color expert.

All posts and framework are of solid maple. The panel work is cherry wood. Tops of chest desk, overbed table and bedside cabinet are high pressure laminate—cherry grained, heat and stain resistant. Although classed as a minimum priced suite, the 8,000 grouping is a Hill-Rom creation in every respect, which means it has been built for value and durability as well as for smartness and beauty.

Shown in the 80-62 Private Room Grouping above are: No. 80-62 Motor Hilow Bed (listed by U.L. for use with oxygen) No. 8003 Bedside Cabinet, No. 80-614 Overbed Table, No. 80-26 Chest Desk, No. 8007 Straight Chair, No. 8008 Arm Chair, No. 306 Lamp and No. 300 Safety Sides. The No. 80-61 Manual Hilow Bed is also available with this grouping.

Write or wire for further information on this grouping.

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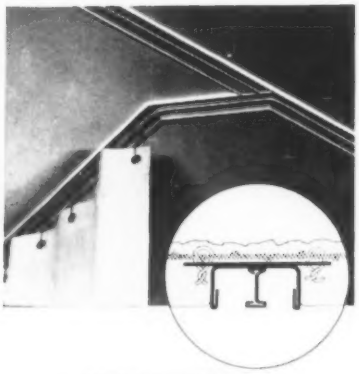

HILL-ROM Recessed-in-Ceiling *Screening*

- No Rod Supports
- No Wall Brackets
- Exclusive I-Beam Track

Hill-Rom recessed-in-ceiling Perfected Screening provides for insertion of the track directly into the ceiling, leaving no exposed fixtures or projections. Designed primarily for use in new construction, or when remodeling is being done. The track is wired directly to the metal lath and stringers—before plastering. Plaster is applied flush with the track. Channel and track may be painted to match ceiling finish, making an installation that is hardly noticeable. This type of screening can also be used with accoustical tile applications.

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By using the standard Hill-Rom screening unit (either type) one-size curtains are used throughout the building. This eliminates confusion when replacing curtains after laundering. Hill-Rom curtains are made of pre-shrunk, vat-dyed Cordette material, in 16′ width, length determined by ceiling height. The rollers are made of machined nylon, insuring quiet operation. Rollers and curtain hooks are assembled in one unit.

Now.. Hill-Rom Safety Curtains *Flame-proof...Washable*

● Hill-Rom, long known for its many contributions to safety in hospitals, is happy to present another "Safety First" item of equipment to the hospitals of America—a Flame-proof Curtain for Cubicle Screening.

The above illustration is from an actual photograph, and shows a test you can make in your own hospital. Hold the flame from a cigarette lighter or lighted match directly against a Hill-Rom Flame-proof Curtain. The cloth will not support a flame. It will only char.

Hill-Rom Cordette, the material used in these curtains, is made flame-proof with a proven chemical process in which the chemicals actually become a part of the yarn. They also tend to increase the tensile strength and abrasive resistance of the fabric. The curtains will withstand repeated launderings without loss of the flame-proof qualities. Neither the color nor "feel" of the fabric is affected. Actually, it will be *softer* after the initial laundering.

Hill-Rom Flame-proof Curtains are available in cream, peach and green shades. Complete information and samples of the flame-proofed material will be sent on request.

HILL-ROM **PERFECTED** Screening

HILL-ROM COMPANY, INC., BATESVILLE, INDIANA

Left to right: Colebrook,* heavyweight; Summit,* Ferncliffe,* both extra-heavyweight; Skyline,* heavyweight.

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tableware

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You can even get a special advertising allowance by keeping the Heinz bottle on the table or tray, where the public can see it—through a special offer called the Heinz Condimental Contract. You don't have it? Then get the facts about this money-saver at once. Ask your Heinz salesman or Heinz Distributor for complete details.

HEINZ 57 KETCHUP & CHILI SAUCE

The Rockette bassinet is of seamless, stainless steel—easily cleaned and sterilized. Full-length piano hinge gives sturdy support to the metal-bound, shatterproof glass lid.

Comfortable working height of the Rockette facilitates care, and safety glass lid permits observation of visceral excursions and changes of skin color during treatment of neonatal asphyxia.

IN NEONATAL ASPHYXIA:

Natural, non-traumatic resuscitation

Rocking provides gentle, non-traumatic activation of the inert diaphragm through alternate excursions of the viscera. Rocking likewise gently stimulates circulation, aids oxygenation of the vital higher centers, until normal respiration is established.

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*Listed by Underwriters' Laboratories for use in hazardous locations.

References: (1) Millen, R. S.: N.Y. State J. Med. 55:779, 1955. (2) Karpovitch, P.: Adventures in Artificial Respiration, New York, Associated Press, 1953. (3) Eve, F. C.: Lancet 2:995 (1932); Eve, F. C., and Forsyth, N. C.: Brit. M. J. 2:554 (1948). (4) Millen, R. S., Rowsom, A. F., and Mayberger, H. W.: Am. J. Obs. & Gyn. 70:1087, 1955.

for simple, non-traumatic management of neonatal asphyxia

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Rocking Resuscitator by **AIR-SHIELDS, INC.**

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An ingenious vaporizer-aspirator assembly provides the Rockette with a steady flow of humidified oxygen, with mild suction available for aspiration during rocking.

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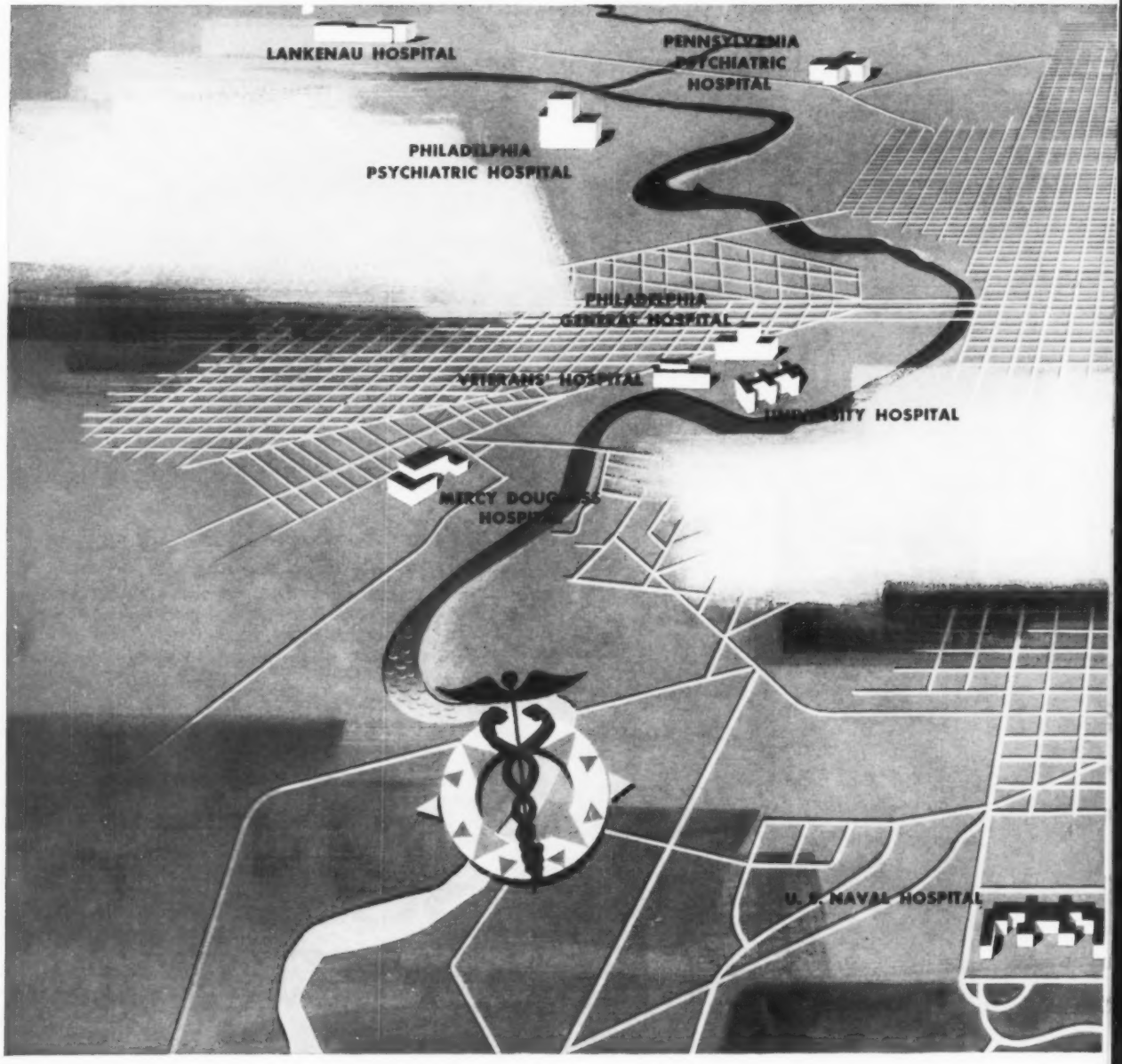
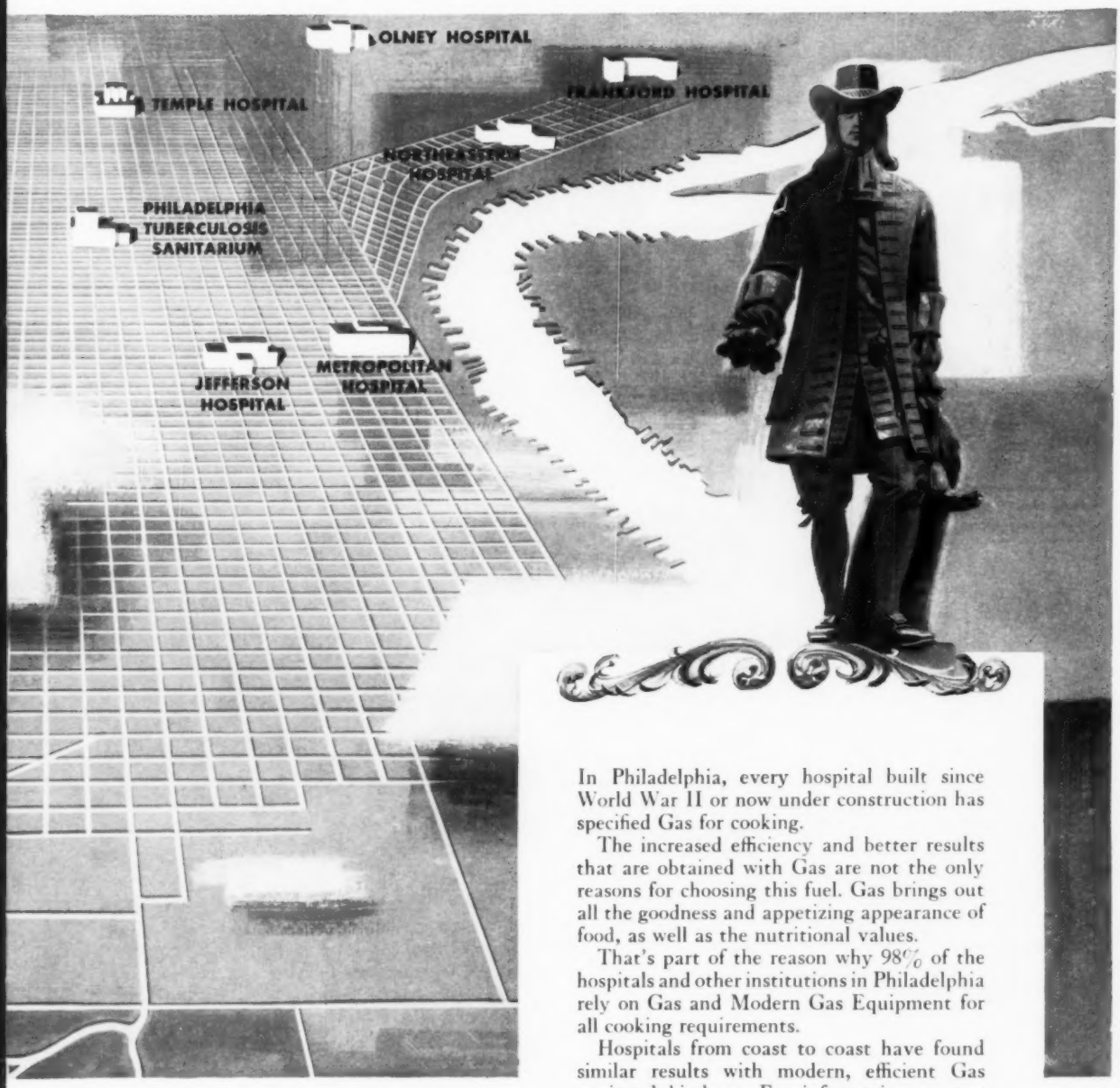


HOSPITALS COOK WITH *GAS*



In Philadelphia, every hospital built since World War II or now under construction has specified Gas for cooking.

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SAYS THE PATIENT

"What a Blessing"
SAYS THE NURSE

"What a Saving"
SAYS THE ADMINISTRATOR

"That's right! Saves me hundreds of miles of walking and untold hours of time!"

ADMINISTRATORS AGREE that Standard-Royal's audible-visible, 2-way system is the most efficient and effective. It conserves the valuable time and energy of nurses. Instead of being errand girls they *now* concentrate on the important tasks for which they have so carefully trained.

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Royalmatic
NURSE SAVER
YOU CAN TALK
WITH YOUR NURSE
ANYTIME!

STANDARD'S ROYALMATIC Nurse Calling System lets the patient talk or listen to her nurse at any time. No one-way, awkward signalling. No nervous fretting while waiting for someone to come and find out what she needs. *Now* patient and nurse can keep in touch at *all* times!

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ADMINISTRATORS, ARCHITECTS, SUPERINTENDENTS, NURSES

Write for Publication 242. It tells you in detail about Standard-Royal Hospital Signalling Equipment.

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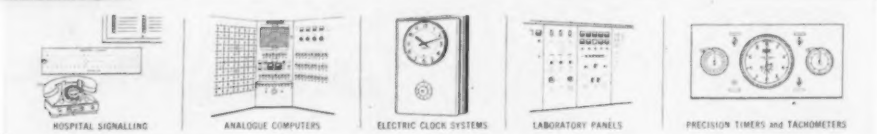

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3. **New case-pack containing six dozen bottles** instead of the usual three dozen.

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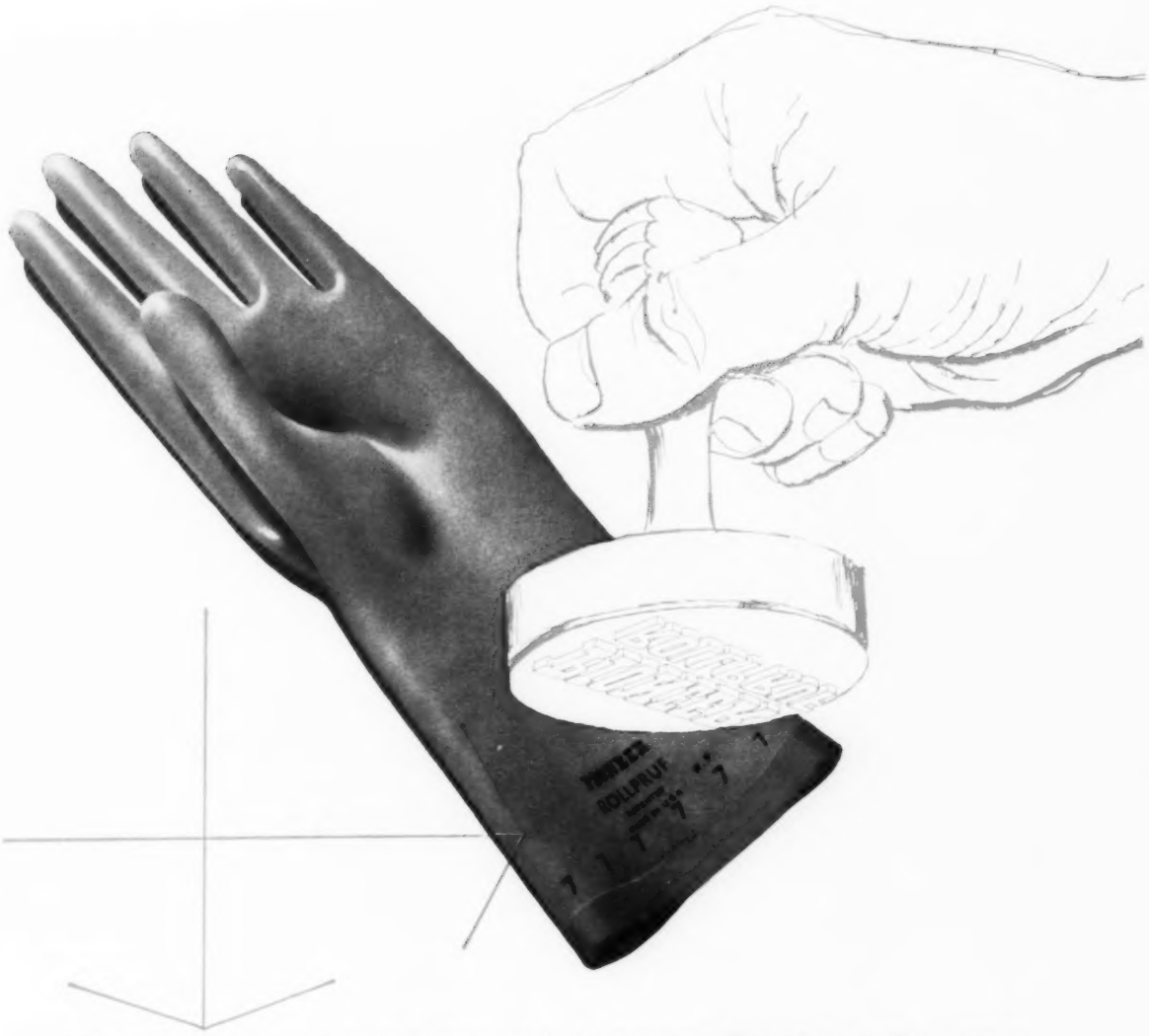

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Rigid Quality Control Every new PIONEER Surgical Glove is the same sheerness as previous gloves, within 1/1000 of an inch tolerance. Surgeons prefer them because every new pair *feels* like their previous pair. No loss of strength after ten sterilizations, excellent condition is common even after twenty!

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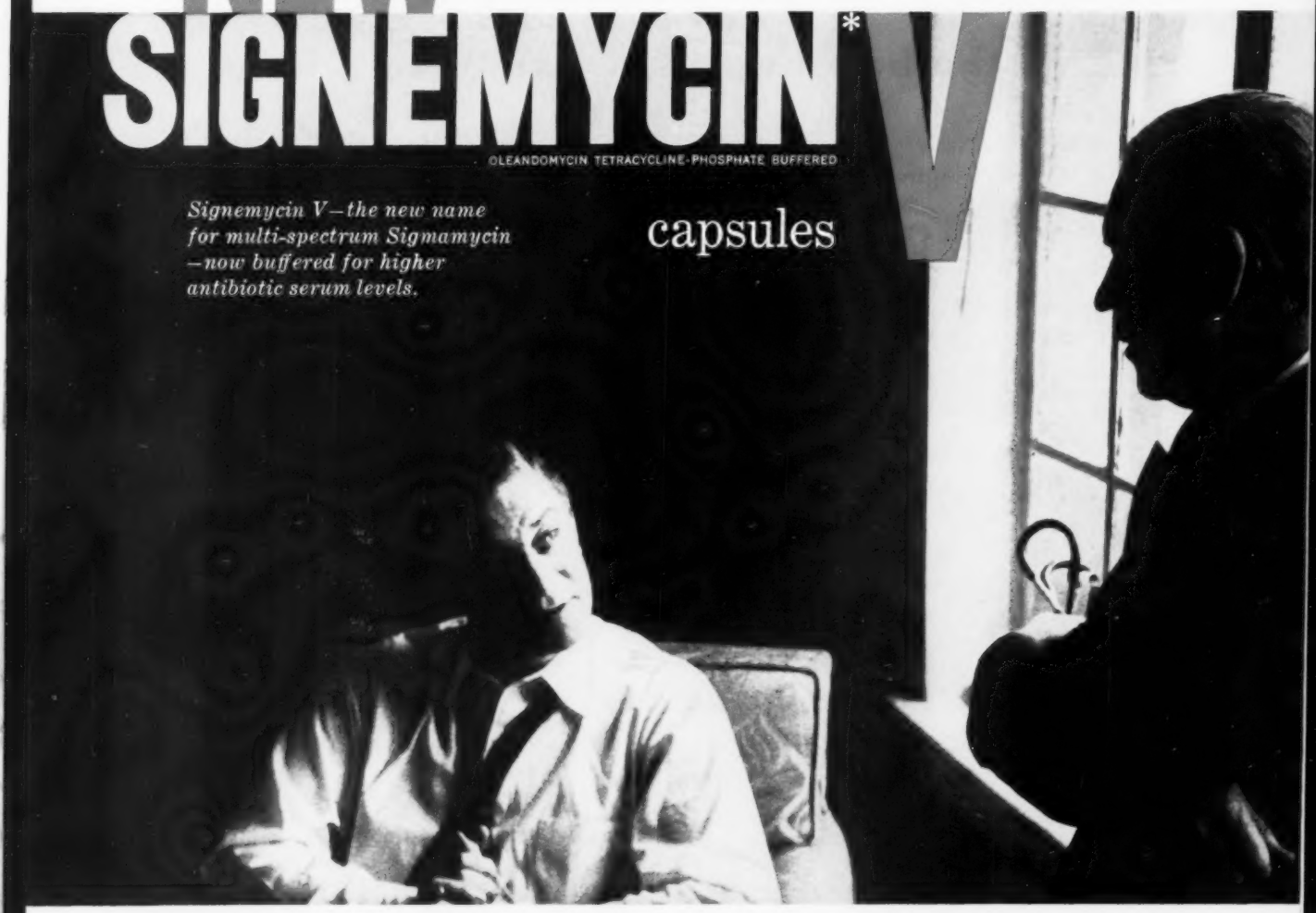

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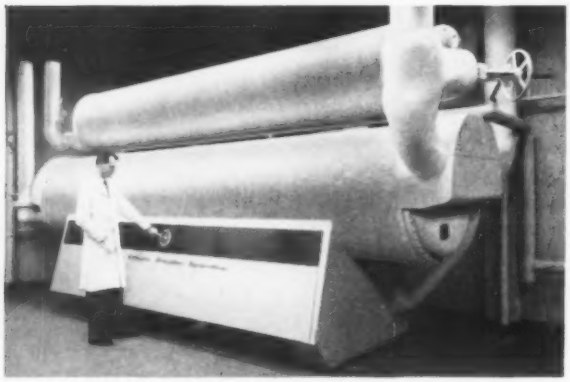

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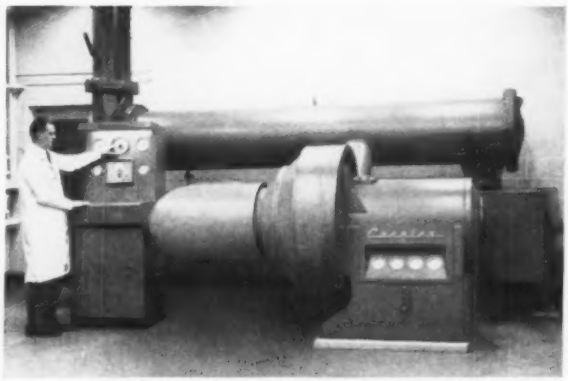

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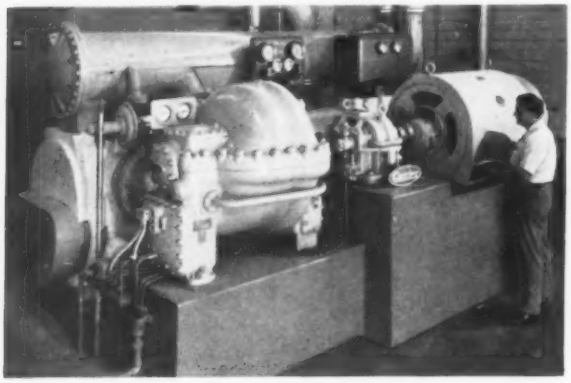

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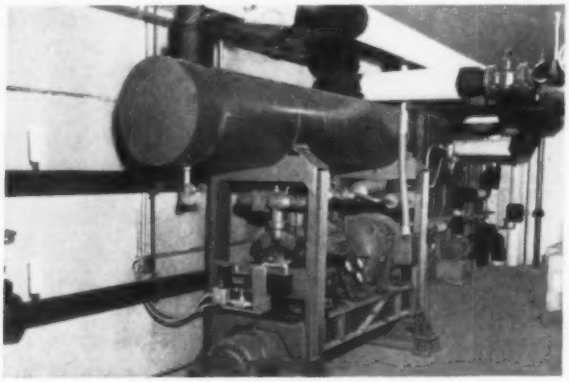

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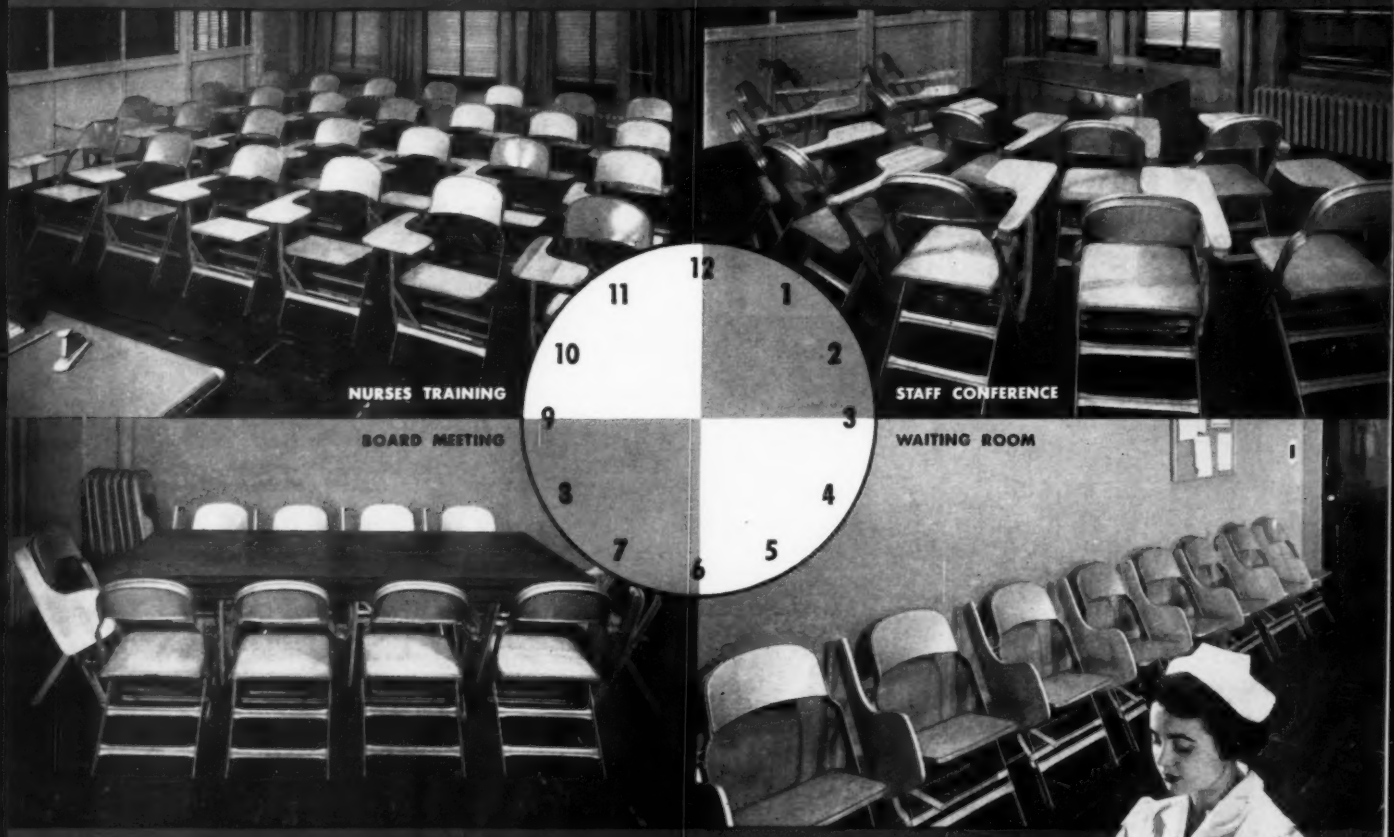

CLARIN Folding Tablet Arm Chairs help solve the problem of overcrowded hospitals! This exclusive, patented chair is actually a chair and a desk in one. In minutes, a single room like the one pictured can be arranged for nurses training classes, staff conferences, board meetings or to serve as a waiting or out patient room. The tablet arm is scientifically positioned for perfect writing height. When the arm is folded alongside, the chair may be used for any normal seating requirement. Only a minimum storage space is needed as the CLARIN Tablet Arm Chair folds to a thickness of just 3 inches.

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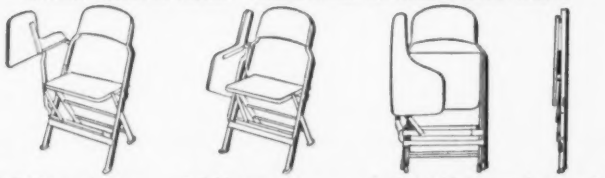

1. Tablet arm lifts to right, making it easy to get in or out of chair.
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3. Chair folds in normal way and tablet arm swings over flat against it. Folds to 3 inches thick.

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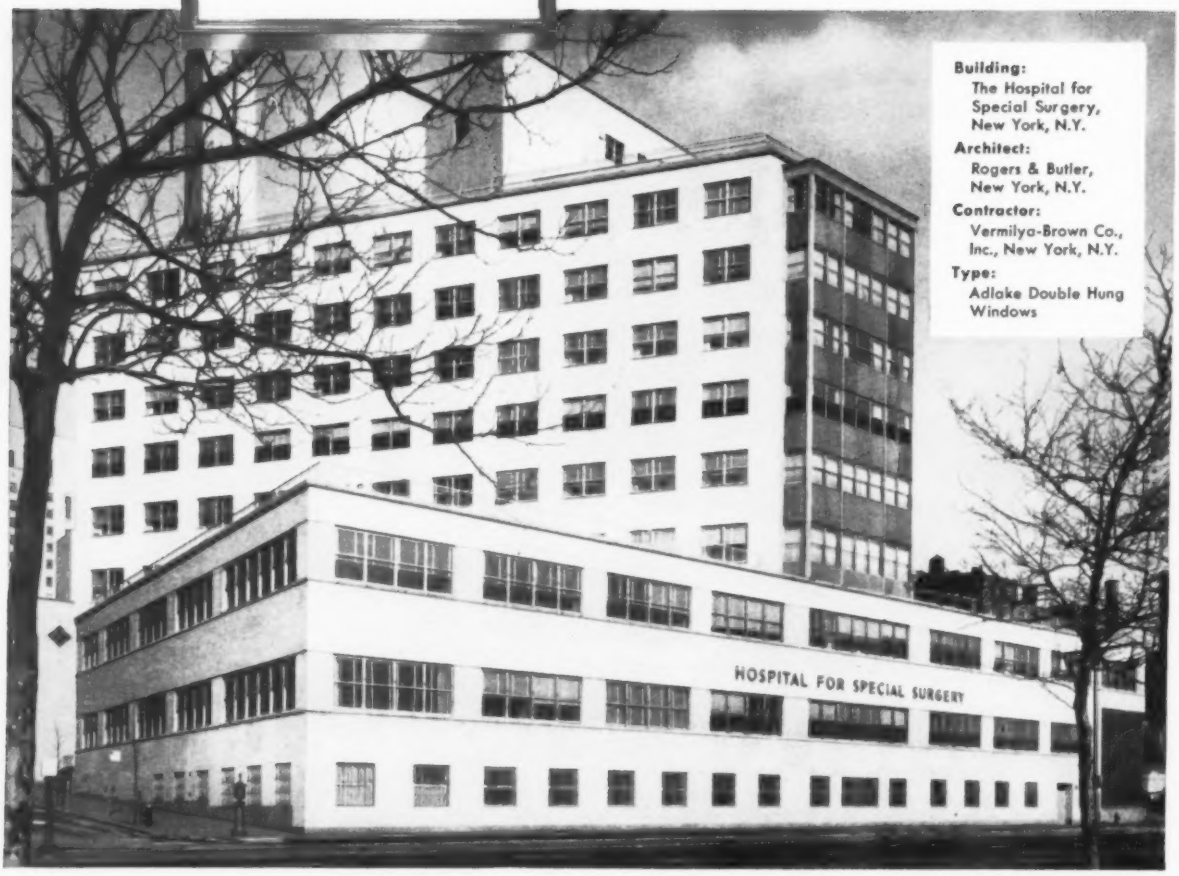

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SMALL HOSPITAL QUESTIONS

Is a Patent Ethical?

Question: One of our staff physicians has developed a new type of instrument and recently applied for a patent on it. Other doctors on the staff say this is unethical and have brought some pressure on the board of trustees of the hospital to have him dropped from the staff. What should the trustees do about this?—J.A., Mass.

ANSWER: Nothing. In the first place, an ethical violation should be presented to the appropriate committee of the county medical society for investigation and action, and the hospital trustees should be concerned about an ethical matter only after the facts are established, or only if such regularly constituted medical authorities have failed to take any action in case of plainly unethical conduct. In the second place, there would appear to be no ethical question here; there is nothing unethical about obtaining a patent on a medical or surgical discovery or invention. The judicial council of the American Medical Association stated recently on this point: "Medicine, recognizing the validity of our patent law system, accepts it, but in the interest of the public welfare and the dignity of the profession insists that, once a patent is obtained by a physician for his own protection, the physician may not ethically use his patent right to retard or inhibit research or to restrict the benefits derivable from the patented articles. A physician who obtains a patent and uses it for his own aggrandizement or financial interest, to the detriment of the profession or the public, is acting unethically."

Who Can Detect an Addict?

Question: On two occasions in the last year, we have employed nurses who turned out to be narcotic addicts; in both these cases, the employes submitted records and references that were satisfactory and gave no indication of the true situation. Is there any way to safeguard the hospital against employing this kind of person? Is the incidence of narcotic addiction among nurses increasing?—R.M.S., Neb.

ANSWER: There is probably no such thing as an absolutely airtight system that will immediately detect any loss of narcotics within the hospital, which would be the best safeguard. The only other protection afforded the hospital is a scrupulous check of the employment records and references of persons seeking employment. Special attention should be given to possible gaps in the employment record, and, in checking references, to the reasons for leaving jobs. With graduate nurses in short supply, hospitals today are often inclined to hire an apparently qualified nurse on the spot, and check references later, if at all. It only takes a few minutes to telephone the director of nursing service at the last hospital where a candidate has been employed, however, and a great deal of trouble may be avoided by adopting this practice.

Compare Pharmacy Services

Question: We are a 55 bed hospital and have never operated our own pharmacy. Our drug room is supplied from the local retail pharmacy, which also fills prescriptions for our physicians. This arrangement is satisfactory to the doctors and to patients. Should we consider establishing a hospital pharmacy service that we would staff ourselves? As long as our present arrangement seems to satisfy the needs of most doctors and patients, what would be the advantage in a separate hospital pharmacy service?—N.U., Wis.

ANSWER: The first step in finding out should be a comparison of your pharmacy costs and charges with those of hospitals of comparable size that have different arrangements — with either full-time or part-time pharmacists, consulting pharmacists, or consulting arrangements, rather than buying arrangements only, with local retail pharmacists. Many hospitals, even in your size group, have found there are economies for patients or better service for doctors, or both, in one of these arrangements. On the other hand, many hospitals do operate satisfactorily, as you have been doing, without this service.

Conducted by Jewell W. Thrasher, R.N., Frazier-Ellis Hospital, Dothan, Ala.; A. A. Aita, San Antonio Community Hospital, Upland, Calif., Pearl Fisher, Thayer Hospital, Waterville, Maine, and others.

Keep Drug Inventory Low

Question: We have a small drugroom, and only a part-time pharmacist consultant, and are troubled by the problem of having to order several different kinds of the same drug for different doctors on the staff, with the result that our inventories are probably larger than they need to be. Is there any solution to this problem short of having a full-time pharmacist and our own "drug list"?—M.C.N., Mich.

ANSWER: Many small hospitals have solved the problem, to the satisfaction of all concerned, by stocking only the one or two brands used by most of the doctors, and, when another brand is prescribed, ordering this from the retail pharmacy in the community, and charging the patient accordingly.

Membership Not Mandatory

Question: We have a provision in our medical staff by-laws stipulating that no doctor who is not a member of the local county medical society may become a member of our staff. This has been in our by-laws for many years and has never been challenged, or caused any trouble. Recently, the hospital attorney, in reviewing the by-laws for another reason, came across this provision and has advised us to delete it, on the ground that it might at some time be challenged by a physician who is not a member of the county medical society, and cause difficulty for the hospital. Is this provision a common one in hospital practice?—V.F.H., Ohio

ANSWER: Yes. It is possible, however, that a question might be raised at some time about mandatory membership in the county medical society as a requirement for staff membership. For that reason, some hospitals have amended this by-law provision to read that physicians must be "eligible for county society membership" in order to qualify for staff appointment. This gives the hospital the protection of the educational and ethical standards for county society membership, without imposing any actual restrictions, and is thought by some authorities to be preferable to the more stringent provision.

wire from Washington

CALLING ALL CARS

American Hospital Association, which expects support from American Medical Association, is moving ahead with plans to petition the Federal Communications Commission to assign radio frequencies to hospitals.

The exclusive channels would be used for professional education, for facilitating medical care, for communication with ambulances and with doctors who are in their cars, and for other purposes.

Dr. George Graham of Schenectady, N.Y., heads the A.H.A. committee, which is a part of the association's Council on Government Operations. A.M.A. also has been interested in the possibility of exclusive frequencies, and a joint A.H.A.-A.M.A. committee may be developed.

At a meeting in Washington, the committee indicated it probably would ask F.C.C. to grant the request on the basis of improving hospital operations in normal times, but would also ask the right to use the channels in periods of disaster. Generally F.C.C. requires that users of exclusive channels be prepared to surrender them if disaster occurs, and forbids use of "disaster" channels for periods of normal operations.

Next step will be a study of F.C.C. laws and regulations to determine just how to make the request for channels.

MEDICARE RESCUED

The Medicare program that for more than six months has been sending several hundred thousand dependents of military men to civilian hospitals almost came a cropper in mid-June.

Now the damage apparently has been repaired, and the civilian dependents will continue to go to the civilian hospitals, as Congress intended. But it was a fairly close call, and not much publicity has been given to the details.

Here is what happened, step by step:

Several months ago the House appropriations committee held closed hearings, as is its custom, on the Defense Department's bill for money for the next fiscal year, which started July 1. Admiral Bart Hogan, navy surgeon general, was one of the witnesses.

In the course of his testimony, Dr. Hogan introduced a number of charts on the Medicare program. Some committee members, puzzled by the figures, asked him to explain.

Dr. Hogan said that the Budget Bureau and the Department of Defense jointly arrived at a figure of $50 per day as the cost to the government for every dependent cared for in a civilian hospital.

He also stated that the "interservice reimbursement" rate arrived at by the bureau and the department, for exchanging medical care costs for dependents in military facilities, had been set at $27.50 per day. As if the committee couldn't get the implication, another navy witness said that care in civilian hospitals, patient by patient, was costing the government between two and two and one-half times as much as care in military hospitals.

Now, because these hearings are in private, and what is said is not made public until the hearings are over, the navy men's statements at first went unchallenged — in fact, they were known to no one except committee members.

Naturally, having only one side of the story, the House committee decided quite properly to act to save the taxpayers' money.

In its report accompanying the defense appropriations bill to the House floor, the committee recommended that the Secretary of Defense amend his Medicare directive to restrict free choice of facilities. Under the law the secretary can specify certain areas in which dependents must receive their care in military facilities, but so far no such area has been set aside.

The committee told the department that it should require that dependents "not use civilian medical facilities unless a positive determination has been made by the appropriate (military) authority that, without augmentation, military facilities in the general area are inadequate to care for dependents."

Had this statement been allowed to go unchallenged, the Defense Department would be under congressional pressure to herd civilian dependents into the military hospitals until all their beds had been used up, with only the remainder allowed to go to civilian hospitals.

This, obviously, would be in direct contradiction to the original intention of Congress, which in passing Medicare last year had specified that it was not to result in "an increase or decrease" in military medical facilities, and that dependents were to have a free choice as between military and civilian facilities. The only exception would be if military facilities were going unused to the extent they would be a waste of taxpayers' money. Thus the committee proposed to shift the burden of proof.

But once the transcript of the navy claims was published, things began to move.

Kenneth Williamson, head of the American Hospital Association's Washington bureau, wrote Senate and House committees that it would be disastrous to eliminate free choice of doctors and hospitals. He declared in part:

"Withdrawal of health personnel from civilian facilities to staff military facilities in order to effect 'the optimum efficient level of operation' would, in the light of the present severe shortages of such personnel, be disastrous for the whole population.

"The operation of the program is undoubtedly a most difficult task. Experience thus far is inadequate as a basis for any general conclusions. On the basis of what we know of the experience to date, however, the program is accomplishing its objectives in a thoroughly competent and wholesome fashion. . . . This association continues to support the dependent medical care program in its present form and

believes that the full utilization of civilian facilities and health personnel in the care of civilian dependents is in the best interests of the nation. . . ."

Dr. George F. Lull, secretary of the American Medical Association, also got into the fray, bringing up some solid statistics to refute arguments of Dr. Hogan and the navy.

Dr. Lull's letter was sent to all members of the Senate and House appropriations and armed services committees. Using information from the Budget Bureau itself, the letter pointed out that the $27.50 "reimbursement" figure for dependent care in military hospitals was completely unrealistic, as it did not take into account many hidden military costs, such as leave and training for doctors, much of the pay for residents and interns, training of nurses, depreciation of property, and so on. Adding on some of these items, the Budget Bureau itself came up with a more realistic estimate of $36 per day as nearer the actual cost to the military.

Furthermore, Dr. Lull pointed out that the $50 set by the military as the per day cost in civilian hospitals was as unrealistic as the $27.50 the military had set for costs in service hospitals.

Dr. Lull cited figures to show that through the first four months of the program, costs in civilian hospitals were approximately $34 per day—not $50. It was conceded that this was unusually low, and would rise to possibly $40—but not to $50.

Armed with these figures, two members of the House armed services committee, Reps. Paul J. Kilday and Leslie C. Arends, took to the floor of the House to straighten out the situation. They noted that the statistics used by the navy witnesses were wide open to criticism, and that great harm would be done if the "free choice" of physician and hospital were to be eliminated.

In the face of the information in the hands of all important committees in Congress, it was highly doubtful that Defense Department would do anything at all about changing the Medicare ground rules.

NEW V.A. POLICY

If administered the way it reads, a new Veterans Administration policy on the hospitalization of workmen's compensation cases could eliminate one cause of serious friction between hospitals and physicians on the one hand and the V.A. on the other.

Under the new rule, V.A. will be expected to exercise special caution about treating a veteran for a condition or illness incurred on or in connection with his job, if he is covered by workmen's compensation. Such cases, of course, would be nonservice connected.

If V.A. learns from any source that the man is covered by workmen's compensation, the V.A. hospital manager will have to point this out to him and ask him to reconsider his "oath of inability to pay," which he signed on entering the hospital.

The assumption is that in most such cases the patient will be willing to make arrangements for care elsewhere, knowing that the costs will be covered by workmen's compensation insurance.

However, if the veteran decides to stay on in the V.A. hospital, despite the advice from V.A. to transfer, the V.A. hospital manager will be expected to caution him that this refusal will be made a part of his permanent records, which will be sent to V.A. headquarters in Washington.

Here are the things the new regulation doesn't do, loopholes hospital managers can take advantage of if they wish:

1. The time lag between acceptance of the patient and the establishment of his right to compensation coverage elsewhere could be allowed to extend so long the policy would be effective only with long-term and chronic cases.

2. The policy states that action shall be taken only after receipt of a "reply" from an employer to establish definitely the fact of workmen's compensation coverage. Should the employer delay his reply, and the V.A. not press the request, the policy would be useless in that particular case.

3. The directive to V.A. hospital managers states that, if the patient refuses to move elsewhere, his record, noting the refusal, shall be sent to Washington headquarters of V.A. The implication is that something drastic will happen—but the directive does not say what will happen. V.A. could just file away the papers and forget the whole thing.

FEDERAL EMPLOYES HEALTH PLAN

The way is now cleared for setting up a broad health insurance program for federal civilian employes. But it seems too late for any action this session of Congress.

The administration's plan was introduced late in June. Most significant of all its provisions is the payroll deduction feature—that up to now the White House has opposed.

Basic and major medical coverage are combined under the plan, which the Civil Service Commission estimates will affect almost 2,000,000 workers. The U.S. would pay $1 a month toward basic insurance for a single worker, up to $3 for one with dependents. For major medical (catastrophic) coverage, the U.S. would pay 25 cents a month for a single person, 75 cents for one with dependents.

In an attempt to mesh the proposed catastrophic program with basic insurance as now operating, benefits under the catastrophic part of the plan would start after the patient had been hospitalized for 70 days. Payments under the catastrophic program would be 75 per cent, with the insured paying the remaining 25 per cent.

NOTES:

Although Small Business Administration almost exhausted its lending funds by July 1, it will be back in business again shortly, with loans for hospitals and nursing homes, among other institutions. Since last fall S.B.A. has been offering loans to hospitals and nursing homes, but fewer than 75 have applied. The hospital must be proprietary and of 100 beds or less. The only nursing home requirements are that they be proprietary and be capitalized at "less than a million dollars." Maximum loans are 10 years, plus time required for construction. Interest is up to 6 per cent if handled through a bank, but straight 6 per cent if obtained directly from S.B.A.

American Hospital Association appears to have won its fight to have part of the federal housing funds set aside for loans to hospitals for construction of housing facilities for student nurses and interns. The figure has been reduced, however, from the $150 million asked by A.H.A. to $25 million—still enough to help a great many hospitals. It would apply only to hospitals not a part of medical schools; medical school hospitals are eligible under present law.

As anticipated, Congress forgot all about budget cutting when it got to funds for medical programs. On top of increases in research budgets voted by the House, the Senate added new increases. The Senate accepted the House-approved figure of $121,200,000 for Hill-Burton hospital construction program without argument, meaning that this item did not have to go to the conference committee.

The Modern Hospital
JULY 1957

A.M.A. ADOPTS NEW PRINCIPLES OF ETHICS

Delegates delete "exploitation for profit" clause from new code as irrelevant to ethics, but request education of physicians and public on evils of corporate practice

New York.—The physician who works for a hospital that collects fees for his services may be unpopular, but he isn't unethical.

This question was settled here June 6 when the House of Delegates of the American Medical Association finally adopted the revised Principles of Medical Ethics without including a specific ban against "corporate practice of medicine" urged by many members, notably including radiologists, pathologists and anesthesiologists.

Specifically, the disputed Section 6 of the revised Principles was approved as follows:

"A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill, or tend to cause a deterioration of the quality of medical care."

After prolonged discussion in hearings conducted by a reference committee on amendments to the A.M.A. constitution and bylaws, considering the revised Principles, an additional phrase—"or permit the exploitation of his services for financial profit"—was deleted from Section 6 as approved by the House of Delegates.

In taking this action on the Principles, however, the reference committee and the House made it clear that the A.M.A. was not changing its attitude toward corporate practice. In a concurrent action, the House reaffirmed the 1951 "Guides for Conduct of Physicians in Relationships with Institutions," which include the stipulation that "a physician should not dispose of his professional attainments or services to any hospital, corporation or lay body, by whatever name called or however organized, under terms or conditions which permit the sale of the services of that physician by such agency for a fee."

In addition, the report of the reference committee as approved by the House emphasized "the necessity of informing all physicians and the general public as to the evils which may be inherent in the socialization of medicine through corporate activity as well as by government action," and requested the A.M.A. board of trustees to "devise and initiate a campaign to educate both physicians and the general public as to the dangers inherent in the illegal corporate practice of medicine in its various forms."

Possibly suggesting the direction that such an educational campaign might take, the reference committee mentioned the "probable deleterious effects" of corporate practice on "the future of medicine and the care of patients."

In many of its forms, the committee warned, corporate practice is "indistinguishable in practice and effect from socialization of medicine and appears to embody all of its evils."

Explaining its reasons for recommending omission of the phrase about "exploitation for financial profit" from the Ethics, the committee said:

"The term 'exploitation' is thought by many to be difficult to define and in many instances would require a financial audit to prove its existence. This is not in our judgment a proper basis for determining an ethical standard. The 'Guides' previously referred to, and hereby recommended for your reaffirmation, make it clear that the type of financial arrangement between a physician and a hospital, corporation or other lay body is important and relevant in determining whether or not such an arrangement is ethical. We

NEW A.M.A. OFFICERS

New York.—Dr. Gunnar Gundersen of LaCrosse, Wis., was named president-elect of the American Medical Association at the 106th annual meeting here last month. He will succeed Dr. David B. Allman of Atlantic City, N.J., who took office during the meeting. Other newly elected officers are: vice president, Dr. Jesse D. Hamer, Phoenix, Ariz.; trustees: Drs. George M. Fister, Ogden, Utah; Cleon A. Nafe, Indianapolis; James Z. Appel, Lancaster, Pa., and Raymond M. McKeown, Coos Bay, Ore.

further believe that the amount of a physician's income or whether or not an institution is making a profit on his services is irrelevant in determining whether an arrangement is ethical."

In another section of the revised Principles of Ethics, the A.M.A. left a loophole for physicians who sell drugs and eyeglasses. "Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient," says the final sentence in Section 7—notwithstanding an apparent conflict, pointed out during the reference committee discussion, with the opening sentence of the same section, which states that "in the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients."

The troublesome matter of fee splitting is dispensed with in a single sentence, considered inadequate by the American College of Surgeons but approved without other objections: "[A physician] should neither pay nor receive a commission for referral of patients."

In adopting the revised Principles, the House of Delegates completed a reform that was undertaken by the Council on Constitution and Bylaws five years ago, under the leadership of Dr. Louis A. Buie of the Mayo Clinic, now a member of the A.M.A.'s Judicial Council. Speaking at the reference committee hearings on the revised Principles, Dr. Buie pointed out that the revision reduced the Principles from a document of more than 8000 words to one of less than 500 words. "But all the essentials are covered," he added, "and all situations couldn't be covered in 800,000 words."

Interpretation and enforcement of the Principles must be carried out by local medical societies, Dr. Buie said, and local enforcement groups would be aided by a manual annotating decisions of the A.M.A. Judicial Council on ethical problems, which would soon be available.

"Principles of Ethics have nothing to do with law," Dr. Buie concluded. "Some people need policemen and jails."

At several points in the discussion of corporate practice, the doctor's old fear of hospital authority was apparent, and John Lansdale Jr., attorney for the Ohio State Medical Association and the American Society of Anesthesiologists, pinpointed a sentiment that was obviously widely felt when he said, "Control of the practice of medicine is the goal of the professional hospital administrator, and he is working night and day to accomplish it."

Some of the same feeling was manifest when the reference committee on medical education and hospitals considered an Illinois resolution condemning compulsory assessment of staff members by hospitals in fund-raising campaigns. During the discussion, Delegate Frederic S. Ewens of Manhattan Beach, Calif., related how staff members themselves took over when directors of the Santa Monica Hospital asked the staff to contribute $250,000 to a capital fund drive. "We wanted to do it our own way," Dr. Ewens said.

The doctors' way, in this case, turned out to be a system of charges for use of hospital facilities, Dr. Ewens explained. Each doctor is charged 75 cents a day for the first 10 days for each of his hospitalized patients; the anesthetist pays 60 cents per anesthetic, and the pathologist and radiologist 2 per cent of the income of their departments. "We have our own secretary, and our own auditor," Dr. Ewens said. "These charges are collected and paid to the hospital fund."

The hospital trustees and administrator had nothing to do with establishing the system of assessments at Santa Monica, Dr. Ewens explained, and the staff itself was well satisfied with the system that had been worked out, but another Californian, Dr. J. Norman O'Neill of Los Angeles, said that doctors in the area were by no means unanimous in their approval of the assessment idea, even under staff control. "It establishes a bad precedent," he said. "We don't want to give hospital administrators any more ideas than they already have."

Reporting for Illinois, Dr. Maurice M. Hoeltgen of Chicago said there had been instances of pressure on staff members by "fund-raising companies." At one hospital, he said, compulsory contributions ranged from an average of $10,000 each for general practitioners to a high of $30,000 for one staff member.

Speaking for the American Hospital Association, Tol B. Terrell of Texas, president-elect, said the A.H.A. two years ago had established a policy against compulsory assessment of staff members in hospital fund-raising campaigns.

In the entire discussion, no instance was reported in which a hospital board or administrator, as opposed to the staff itself, required an assessment or put pressure on staff members. Nevertheless, the Illinois resolution as recommended for passage by the reference committee and subsequently approved by the House of Delegates declared that "physicians in recognition of their community responsibility are aware of and do participate actively in community projects, including various fund-raising campaigns; and such campaigns include a voluntary contribution to hospital building and maintenance fund drives; and a certain few hospitals are taking advantage of this voluntary participation through the promotion of schemes of compulsory donations which are ostensibly voluntary but which amount to an assessment for continuation of staff appointments, thus placing such appointment on a mercenary basis rather than demonstrated ability and proven merit; and such a practice, if continued, could and would lead to a deterioration of medical service in the hospitals."

The resolution then asserted that the American Medical Association "condemns the compulsory assessment of medical men and staff members by hospitals in fund-raising campaigns," and requests that any physician approached in such manner should report the fact to the secretary of his medical society. Copies of the resolution were to be sent to the American Hospital Associa-

(*Continued on Page* 138)

MEDICAL PROVERBS

New York.—Following two hours of discussion on the issue of "corporate practice of medicine" at hearings conducted by the reference committee on amendments to the constitution and bylaws, Dr. Louis A. Buie, former chairman of the A.M.A. Council on Constitution and Bylaws and principal author of the revised, simplified Principles of Medical Ethics, was called on for comment. Said Dr. Buie: "He who thinketh by the inch and speaketh by the yard should be kicketh by the foot."

In another notable contribution to medical oratory, an Indiana physician warned a reference committee meeting that failure to adopt a policy he supported would be "a headache of the last water."

He Learned How Patients Really Feel

He was warned that working with hospital patients would be "depressing" but this chaplain found his hospital experience the most challenging and rewarding of his life, largely because of the courage and spirit of the patients he served

ELIOT PORTER

THIS work has been exciting from the day I began it as one of 30 chaplains-in-training in a general hospital in Boston. How could it not be exciting to know each morning that there were people in that hospital who would desperately need help that day, and that I could bring them within reach of that help if only I could find them and guess—as every chaplain has to guess with every patient—how to bring them there. It was exciting to be, for the first two weeks, an orderly in ill-fitting white in a men's ward for surgical cases, and, at another time, in a men's ward in dermatology. As an orderly you learn things about a hospital you would never learn as a visiting clergyman. In my first two weeks of orderly service I was used as a helper to a male nurse in charge of the ward. In the lack of trained help, he had me take blood pressures, change dressings, remove stitches, and inject penicillin and insulin. Later, in dermatology, I worked daily with patients who suffered from diseases, many serious, some even fatal, which were caused by sheer anxiety.

The training year is interesting for another reason. Some things you learn are quite different from your customary way of working as a minister of a parish.

You are taught to be careful about sympathy—not about feeling it, but about expressing it—since nearly every patient wants to "keep a stiff upper lip," and pity openly expressed may undo him. Nor are you to reassure patients or relatives of patients save on real grounds for reassurance, and never as if you were a doctor. Nor are you to deliver sermons, however short, at a bedside. Instead, you are to keep the patients talking, if they are willing, especially about what makes them glad or mad, afraid or grateful, which is your particular business as a chaplain.

LECTURES BY HOSPITAL STAFF

After two weeks as an orderly you get back into clothes that fit, and listen daily to lectures by doctors, surgeons, psychiatrists, anesthesiologists, radiologists, hospital directors, nursing heads, social workers, and chaplains. You see demonstrations by technicians, and you see postmortems. You observe operations, routine or radical, short or long.

In smaller groups you hear and discuss verbatim reports of calls on patients made by yourself or others in training or by experienced chaplains. You call on a few patients assigned you, more and more of them each day. If you want to, after standing up most of Friday morning and afternoon, you can volunteer for duty in the emergency wards Friday night, that being a rush night because it follows pay day. This will mean you keep on standing up until Saturday daybreak.

There in the emergency wards, between services as a chaplain, you may cut sutures for a surgeon, or swab blood from people crushed in collisions, bashed by robbers, battered by night sticks of police, pitched head-first downstairs in drunken brawls, or cut or gashed in endless manners, some of them all but incredible. You will look into the faces of people burned in explosions—their eyes sometimes the only part of them that seems alive. You may lead some patient in the Lord's Prayer to an accompaniment of blasphemy and obscenity from a gory criminal near by over whom the police are still standing. Your whole night will be crammed with pathos, courage, terror, humor, the twisted logic of alcoholics, and the endless patience of men and women in white.

Even though you are to serve in a general hospital, a quarter of your year of training will be in a mental hospital, where patients are taught to be no more ashamed of mental illness than of physical illness since it is no matter for surprise that the most sensitive and delicately adjusted part of the human structure should get out of kilter. If it is in as good a mental hospital as the one in which I served, you will see no impatience, let alone cruelty, on the part of doctors, psychiatrists, psychologists, nurses or orderlies. In the hospital in Washington, D.C., in which I served, from two-thirds to three-fourths of its 7000 patients are eventually sent home cured. A young motorcycle police-

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The author spent a year in special training for hospital chaplaincy and served as chaplain of Presbyterian Hospital, Denver, for three years. Then for six months he was a traveling consultant for ministers all over the country who were interested in improving their pastoral counseling with the sick.

Condensed from an article appearing in "Presbyterian Life," Jan. 19, 1957. Used by permission.

The comments that accompany this article were submitted by Douglas R. Eitel, administrative resident, North Carolina Baptist Hospital, Winston-Salem, N.C., in connection with the chaplaincy training program at the hospital and the Bowman Gray School of Medicine.

Demand for Chaplain's Assistance Increasing

"The pastoral care program has had a major influence in the over-all program in our hospital. The value of counseling at this level has been apparent to the medical staff on each of the hospital services, and in the years that the program has been in effect there has been an increasing demand for the assistance of the chaplain in the management of physical, emotional and behavior problems in relation to all illness." — Professor of Obstetrics and Gynecology

Chaplains Have Become Part of the Team

"I have been closely associated with the chaplains training program of the North Carolina Baptist Hospital, Winston-Salem.

"To the best of my knowledge it is the first such training program for pastoral counseling and hospital chaplain work in the South. Also, it is one of the first such training programs in the country where the hospital chaplains have become an integral part of the therapeutic team in the clinic and on the wards. The chaplain, together with the social worker, the psychologist and the psychiatrist, comprise the group that works to help the 'patient as a person,' in the psychiatric outpatient clinic and on the wards, and assist the other services in medicine and surgery whenever and wherever needed.

"In my association here, I have observed tremendous growth in the cooperative spirit of Christian service in all branches of the healing art, and I feel that this growth and development of the chaplains department and its fine work have contributed largely."—Professor of Psychiatry

Work Is Essential in Restoring Health

"This department of pastoral care may not be indispensable, but the work it does in collaboration with the medical staff is essential in restoring to physical health many sick people who enter our hospital doors. But the work with our patients and the miraculous results produced are but a small part of the story. It is so much more comprehensive than that. Pastors, medical students, nurses, interns, resident physicians, all need the valuable training this department has to offer. They need to take it wherever they go. My honest opinion is that some day it will be an accepted fact that coordination of the two great fields of service, medical and religious, is essential for restoration to health of sick people everywhere. At North Carolina Baptist Hospital we are pioneering in this great work, and we are seeing results that I would not have thought possible a few years ago." — Trustee, North Carolina Baptist Hospital

man, who late one night ran me into the curb for driving too fast across a bridge, took down my name and license number, and then asked what I did. When I said I was a chaplain-intern at St. Elizabeth's, he slammed his book shut, looked up at me with a grin, and said, "Three years ago I was a patient there. Go ahead."

At last I had my own chaplaincy in a hospital with 198 beds, nearly always full. The ideal is 200 patients for one chaplain, we have been taught, and I had within 1 per cent of that. With hospital stays averaging a week, nearly 30 new patients were therefore admitted, on the average, each day of the week. Now nobody knows any test by which to tell who will eventually need you most among those 30 new patients. You soon learn it is not likely to be those who are delighted to find there is a chaplain in the house, and have you pray for them, and go home in a week or so cured and happy. You are glad to serve them, but most hospital chaplains I know take as their special assignment the wary patients who are not used to being on familiar terms with clergymen, and do not yet expect that they will ever ask anyone to pray for or with them, and have never faced a situation too big for them to handle by themselves alone. They are not ready yet, in other words, to accept any "preacher," let alone a strange one, as their spiritual adviser.

When you find one of these persons, you tell him, as you tell the other patients, that you are the hospital chaplain, that few patients escape you, and that you hope he has an encouraging time during his hospital stay. If, as is often the case with newly admitted patients, he is due for surgery the next morning, you wait a moment until you are sure you mean it, and add, "God bless you tomorrow, and your doctors, and your family." The patient may not even thank you, but you don't impose prayer on one who takes his hospitalization lightly and who, though courteous, seems uninterested in your reason for being there. You do not resent this lack of interest, or are you surprised at it. Least of all do you lose interest in such a patient.

On the contrary, you are particularly concerned about him. Every day or so you see him briefly. Then some evening, when the daytime rush of hospital life has died away and patients have grown thoughtful and communicative, the wary one may "beat you to

the draw" and say, "Hello, Chaplain," as if he were really glad to see you. You know then that he is lonesome, and probably tired of being treated merely as a physical body that has got out of order.

So you find if there is something he wants to talk about—something, it may be, that would be more easily discussed with someone he is not going to see every day when he gets home again. Or if he is lonely, yet doesn't have much to say, you draw a bow at a venture. If he is a rancher, maybe you ask him if he would choose ranching again with beef selling for what it does. At this he may forget where he is and tell you what he thinks is the matter with the cattle market; and why he would be a rancher in spite of anything; and how he likes his Angus cattle, and the feel of his own land under the flat of his feet and the mountains that look down on his place.

If his doctor happens to look in just then, and sees the light in his patient's eyes, he may flick a glance at you as somebody who is on his side. But though you are glad to help his patient forget pain or boredom or anxiety, and though you find it everlastingly interesting when people tell you what makes them enthusiastic or what makes them mad, whether it is children or wife or husband or business or church or hobby or favorite vacation country or early memories, you have this greater reason for satisfaction, that this man has become your friend. Now you can pray for him whenever you are moved to do so. If he is discouraged at delay in diagnosis, or gets good news or bad from his doctor, or his pain is worse or disappears, or he is distressed about something in his past, or grows anxious about his family, he knows now that to you he is no mere "statistic." In the face of trouble or joy you can conclude your prayer for him with the Lord's Prayer, in which he may join you or for which he may thank you, and so lift up his hand into the hand of a God who sees us through whatever may be our lot. These shepherdless ones are those about whom a hospital chaplain cares most of all.

Day after day you walk the same corridors and enter the same rooms, no work outwardly more monotonous, nor more endlessly different each day. You come to work six days a week, like a banker at 9 or even 10 in the morning, but you don't go home until 9 or 10 at night because most of the patients due for operation the next day

There Is Need for Clinical Pastoral Care

"As a minister, I am keenly aware of the need for this clinical pastoral care. I have had several courses in college and seminary in the lecture aspect of the work but have not had the clinical work as offered in the pastoral care department at the hospital. I have been out of the seminary for about five years. I am continually faced with problems in the pastorate that require counseling. If I only had some clinical experience along with the lecture courses I believe that I would be in a better position to counsel with these people."—Minister Applying for Admission

Most Significant in Theological Education

"One of the most fortunate arrangements made by the seminary in its history is that which we have established with Dr. Richard K. Young of the Bowman Gray School of Medicine and the Baptist Hospital in Winston-Salem. The field of pastoral counseling is rapidly becoming one of the most significant in theological education. It was our desire from the beginning that every man who graduates from the seminary should have the best help possible to enable him to deal with the personal emotional problems of members of his future congregations. We believe Dr. Young is as well qualified as any man in this whole field, and we consider ourselves most fortunate that he is able to give all of our students the introductory course in the field of pastoral counseling and to permit them to enter classes conducted in Winston-Salem for advanced study if they plan special work in the field. We are proud of the fact that these three great institutions have been able to work together in this proper and significant field."—President, Southeastern Baptist Theological Seminary, Wake Forest

Helps Physicians in Care of Patients

"As one of the Bowman Gray faculty and a member of the hospital staff, I am greatly impressed by the increasing usefulness of this department in counseling patients, medical students and their wives, nurses, and others; in training young ministers as hospital chaplains, and in giving systematic courses to pastors in patient care.

"Together with other physicians on the hospital staff, I have been helped many times in the care of my patients, for so many of them have emotional problems. I have come to regard this department as an essential part of our medical center and look forward to a continuous expansion of its usefulness."—Acting Dean, School of Medicine

This Is My Most Outstanding Experience

"May I thank you again for permitting me to attend the counseling sessions and training at the Baptist Hospital in Winston-Salem. It is truly the most outstanding experience of my life. Some have asked me about my work there. We have lectures from the hospital chaplains, psychiatrists, surgeons, physicians, nurses and so on. We are assigned eight patients each, or three rooms. These are ours for six weeks. We minister to them as best we can. In a seminar we discuss our methods of ministry, our counseling, our personal problems, our work at large, in which the Christian fellowship is created. The rest of our time is spent in reading. I have been privileged to witness an all-round ministry to the patient given by doctors, nurses, attendants of dozens of kinds, chaplain, psychiatrist, and many other types of service."—Minister Who Has Completed Course

This Program Is a Valuable Asset

"We have great hopes that the department of pastoral care will in the future be able to enlarge its activities in order that more time may be given to case discussions with medical students, nurses and faculty members so that each group will learn how it can support the others in the common goal of physical and mental betterment of the patient.

"I heartily endorse this program as a valuable asset to the Bowman Gray School of Medicine and the North Carolina Baptist Hospital."—Acting Director, Department of Preventive Medicine

arrive the afternoon before. So many staff people must see them that it may take hours for a chaplain to reach them all. Late afternoon and evening are the best part of the day for calling anyway, I soon found out.

Sunday afternoon and evening are busier than ever for a chaplain, because the turnover in patients is greatest then, and radical surgery is often scheduled for Monday, when surgeons are rested. Sunday morning, however, is a chaplain's free time, for few patients are ready to be visited until nearly noon because of morning nursing care.

After a year or so you stop counting the calls because it is too difficult to distinguish between looking in for a nod and a word or two, and a real call. The only statistical track I kept of myself after the first year in Denver was the quarterly percentage of patients who got out of the hospital without my finding them. Without outside appointments and conventions and the like, I could keep this percentage at five or lower and yet spend a morning or a night with somebody in special need, no matter how many new patients escaped me.

Except at the few periods when the hospital was not crowded with patients, I found I had a slight aversion to new patients as yet unseen by me because they threatened to keep me from knowing better those with whom I was already acquainted and of whose needs I was aware. To succumb to this would soon have left me ministering to a mere handful of veterans. Against it, the thought of the percentage of discharged patients who had not been seen by me proved a wholesome deterrent.

At any rate, a chaplain's work is a six-and-a-half-day assignment. He loves it when he is on top of it, and he dreads going away from it for needed change, because it takes so long to catch up when he returns. He goes away for occasional breaks because he finds himself, otherwise, going about his duties mechanically, and this type of work is worse done that way than not done at all.

A surprising number of people had told me that hospital work would prove depressing. I found it inspiring instead. Think what it means to have known a traveling salesman who two days before he died, as he had known he would, of a dreaded and painful disease, offered a prayer heard by his wife and sister in which he thanked God for various ways in which he had been blessed, and ended his prayer, "My cup runneth over."

In a Boston hospital was Mrs. Betty from the White Mountains, who lay a long time with nothing much left of her save her gallant spirit. But when she opened her eyes, there was beauty in them of a kind never seen on a magazine cover. She said the fall colors were at their best from the window at which she washed the dishes. Her husband said she told him not to leave the ink bottle in their hidden cabin in the woods lest it freeze and break and leave him trouble to clean up in the spring. She would not be there then, but he and she—both retired school teachers—spoke as if she were going to Europe or Africa on some assignment before they would be together again. Think of being allowed to pray for people like that.

I remember a huge Negro stevedore paralyzed below his ribs, without chance, it seemed, of improvement, by a chain that snapped and wrecked his spinal column. His body, grown soft yet still magnificently proportioned, looked, when propped up in bed with white linen all around, like a monstrous tar barrel. When he talked, a gold tooth in the middle of his mouth flashed short and long, long and short, as if in international Morse. He had spoken of suicide, I knew, before he was assigned to me, and had escaped from this mood by teaching an Italian boy in the same ward, paralyzed by polio, to stop his daylong sobbing and smile and even sing a song called "Beautiful Brown Eyes." After that, as often as he was allowed, the boy wheeled himself over in his chromium chair to sit and look up at this huge, smiling friend of his.

I called this man "The Emperor Jones," and, having seen the play, he roared with laughter when I told him

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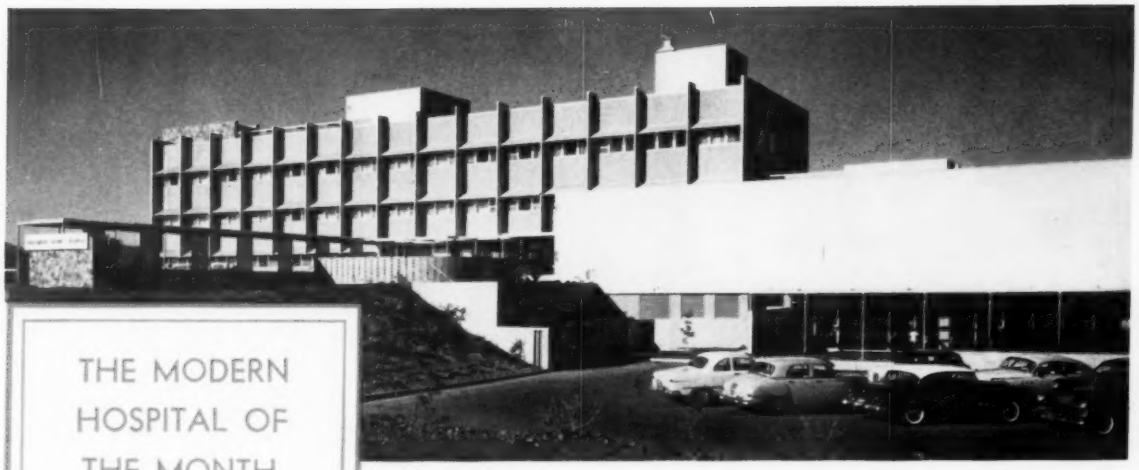
THE MODERN HOSPITAL OF THE MONTH



Grossmont Hospital was built to give patients a view of the surrounding country. The doctors' parking area and the cafeteria may be seen in the foreground. A color photograph of the hospital entrance is on this month's cover.

Expansible Plan Contracts the Cost

The construction method of this hospital has made possible many practical economies which permitted the architects to make use of the highest quality of materials at below-average cost per square foot

LOUIS M. PEELYON

AFTER the architects' drawings have been filed away for future reference and the contractors have moved the last pieces of construction equipment; after the dedication speakers' words have become part of the history of a community and the hospital organization committees have heaved a sigh of relief that their dream has come true—then comes the test of all that has gone into the months and years of planning and building a hospital.

Then the administrator and his staff must determine by operating experience just how well they and their committees have planned. Then it becomes evident whether theories will be translated into functional efficiency, adequately serving the needs of the patients at costs that are within the means of that particular community. The test of the theory that, in addition to convenience, this arrangement would provide specific economies in

(*Continued on Page* 58)

Mr. Peelyon is administrator of Grossmont District Hospital, La Mesa, Calif.

OUTLINE OF CONSTRUCTION COSTS

Total project cost (including Groups 1, 2 and 3 equipment; soil and site surveys; architects' and consultants' fees)		**$1,634,323.00**
No. of beds	**105 *(planned for 150 additional)**	
Cost per bed		**15,565.00**
Total square feet	**63,187**	
Square feet per bed	**602**	
Cost per square foot		**25.86**
Total cubic feet	**786,566**	
Cubic feet per bed	**7,491**	
Cost per cubic foot		**2.08**

*If all rooms are used as two-bed rooms

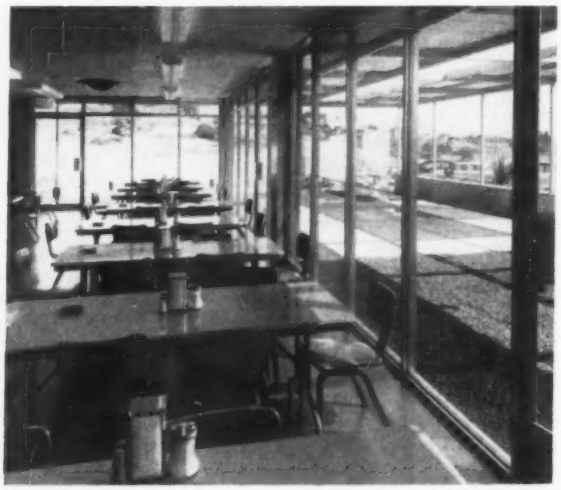
Lobby interior, looking south down entrance corridor. Auxiliary member greets patients and their families at door.

The doctors' lounge contains a small library of magazines and books. On the left wall is the doctors' paging system.

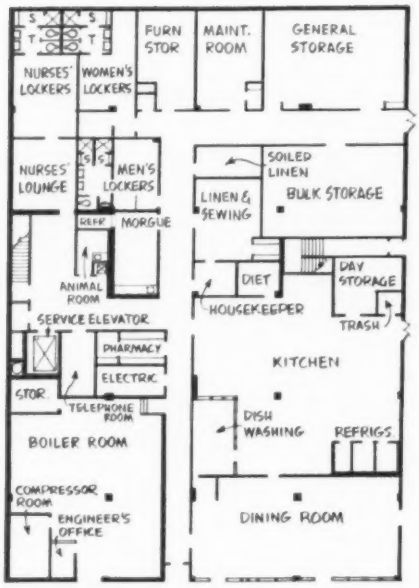
Beds are placed against opposite walls in patient rooms to provide direct access to a window for both the patients.

The open design of this nurses' station gives freedom of movement, while promoting a cordial hospital atmosphere.

A service to visitors is the attractive hospital gift shop, with its selection of books, cards, magazines and small toys.



The staff cafeteria is on a lower floor, set apart from normal hospital traffic by natural slope of the building site.

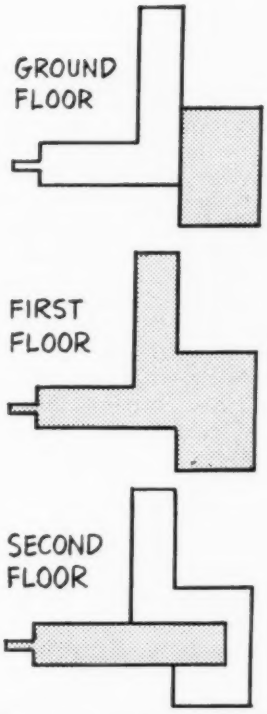


GROUND FLOOR

The hospital presented here has been selected as The Modern Hospital of the Month by a committee of editors. Award certificates have been presented to the hospital and the architects. A similar award will be made each month.

KEY PLANS

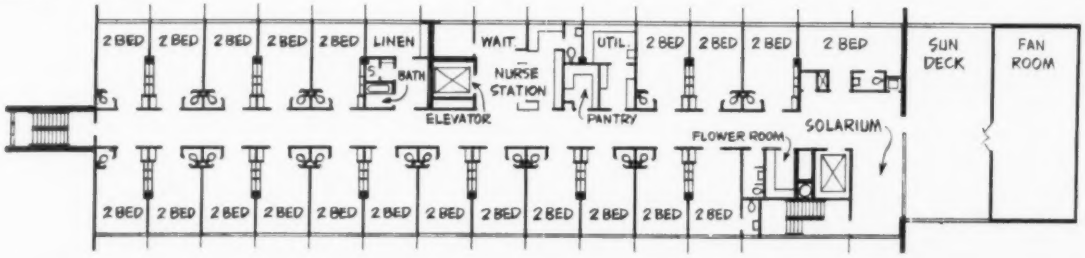
The key plans of ground, first and second floors at right show by the shaded portion relative areas of each floor.



FIRST FLOOR

Floor plans of Grossmont Hospital. The most striking feature, in the administrator's opinion, is the inclusion of all treatment and diagnostic functions on the first floor, arranged to permit visitors to move freely without getting in the way of staff members.

SECOND FLOOR



Modern Hospital of the Month

(*Continued From Page* 55)

the operation of the hospital came soon after the hospital opened to receive patients on Aug. 15, 1955.

The first physician using Grossmont Hospital at La Mesa, Calif., was an obstetrician, who delivered the first baby born at Grossmont, about 30 minutes before the official opening had been planned. This particular doctor had not been in the delivery room since the equipment and supplies had been placed. It was necessary for him to perform the delivery without the customary assistants, since they were not scheduled to arrive for another half hour. Operating under such adverse conditions, the doctor reported later that as he reached for each item he needed, it was, without exception, exactly where he would expect to find it. Lack of advance inspection of the equipment and supplies proved to be no problem.

The construction of Grossmont Hospital has afforded many practical economies, which have made it possible to utilize only the best of materials in a building for beauty as well as performance and to do so at a cost per square foot that is well below average.

The most striking feature of the plan is inclusion of all treatment and diagnostic functions on the first floor, so arranged as to reduce inhospital traffic and confusion and to give freedom of movement of visitors to the hospital.

A personnel saving innovation at Grossmont is the use of an automatic compressor to provide high pressure steam during 16 hours of the day, making it necessary to operate the high pressure steam boiler only during the regular eight-hour shift of the chief engineer and his assistant. During that 16 hour period, the second boiler is operated at low pressure, and can be

ARCHITECT SAYS: "SOLID WALLS SHOULD NOT HAMPER FLEXIBILITY"

JAMES S. MOORE

THE architectural firm of Pereira & Luckman, Los Angeles, was called in at the beginning of the project and aided in site selection and initial programming.

Many deviations from standard planning were studied. The structural system was actually designed in nine different ways, including lift-up, steel frame, concrete and so forth. These systems were priced, and there was considerable variation among them.

The structural system decided upon is ideally suited to this hospital. The 9 foot cantilever on the nursing unit floor worked to advantage. The use of a light curtain wall on the exterior was important in keeping the total weight of the structure to a minimum, a definite advantage in areas such as southern California where earthquakes must be considered.

Much study was given to possible expansion, as well as to remodeling, of the existing building. The architects feel strongly that medical science is progressing so rapidly that solid walls should not restrict or hamper the adaptability of these technics to existing facilities, or to future planning. Therefore, clinical and surgical facilities have been enclosed in a windowless, air conditioned box. All are grouped closely together to consolidate expensive plumbing and air conditioning runs. The roof over this area is supported by trusses that span the entire width of the area, thereby eliminating columns which would hamper any future alterations.

Mr. Moore, who was project architect for Grossmont District Hospital, is a member of the firm of Pereira & Luckman, architects, Los Angeles.

HOW TRAFFIC IS CONTROLLED

The value of this study is already evident, since additions are being planned at this time. The expansion can be accomplished without great cost or inconvenience to the existing operation. The central medical supply was located so that the same personnel and equipment could serve both surgery and delivery suites without contamination.

Traffic has been controlled by separating the two elevators. One serves the in-hospital traffic at all times, and the other is used by visitors, but, of course, serves the hospital staff also. This separation would be an advantage in case of a fire or building damage in the area of either elevator.

The slope of the site was used to separate the service facilities from normal hospital traffic. The visitor or patient never passes through the service area. The cafeteria and meeting room on the lower floor has a view of a tree-lined water reservoir that is most pleasant. The hospital is oriented to take advantage of an extremely beautiful site.

The emergency suite is so located that the hospital can serve accident victims without their actually entering the heart of the hospital unless major surgery is needed, yet all of the facilities are immediately available.

The maternity area is so planned that, although it is closely tied to the clinical area for in-hospital functions, visitors will feel that it is a separate pavilion. Visitors to other patients in the hospital have no contact with maternity patients. Patient rooms in this area are larger, on the assumption that maternity patients are different from acutely ill general hospital patients. A large glass enclosed lounge has been provided at the end of the maternity unit.

The nursery is located at the entrance to the corridor so that family members may view the baby without actually entering the maternity nursing area.

CONSULTANT SAYS: "THE STRUCTURAL SYSTEM IS HIGHLY EFFECTIVE"

CONSULTANTS to The MODERN HOSPITAL selection committee commented on Grossmont Hospital as follows:

We particularly liked:

The structural framing system used for much of this project which consists of a two column transverse rigid frame with cantilever extensions to support the exterior wall. This haunched transverse frame is an effective structural system as it supplies the necessary structural strength in direct proportion to the need. Placing the columns several feet from the exterior wall permits a high degree of flexibility in exterior wall and window arrangement.

The clinical, surgical and nursery areas are air conditioned with 100 per cent fresh air. The maternity and general nursing areas are heated and ventilated by a single duct system utilizing 100 per cent fresh air. Provision has been made for future air cooling of these areas.

We have some reservations about:

The layout of the block containing surgical and diagnostic facilities.

Ease of expansion of this block.

The emergency layout, with the bath and toilet inside the emergency operating room.

The 105 bed count, which would probably be about 80 beds if one-third were in one-bed rooms. (See administrator's comments.)

The 3 foot projecting fins, which decrease the patient's viewing angle.

The advantages of the staggered bed arrangement.

The necessity of larger rooms for maternity patients.

The sliding doors at the 3d floor utility room, with door pockets inaccessible for cleaning.

The future location of additional elevators when 150 beds are added.

The automatic compressor and the total possible savings.

converted to a high pressure operation when the hospital is enlarged to its ultimate capacity of 260 beds. Meanwhile, this arrangement permits a saving in engineering labor estimated at $14,000 a year.

A unique feature of the hospital is the heading of the two beds in a room against opposite walls. Tracks placed in the ceiling permit curtaining both beds for privacy, while giving both patients direct access to a window. This not only overcomes the objection of many patients to being cut off from an outside window but has an added advantage at Grossmont, located on a hilltop in the foothills of eastern San Diego County, where each patient is afforded a striking view. This has met with enthusiastic comment from patients.

All rooms and each bed in the hospital have their own piped-in oxygen supply. Beds have telephone service available and a communicating system to permit talking directly to the nurse. A pillow loudspeaker provides a selection of recorded music or three radio stations. Television service is available with either conventional or pillow speakers.

The lobby design has attracted frequent comment from patients and visitors, who say it gives the feeling of a "resort hotel" rather than a hospital. This design has encouraged the operation of a hostess service by the women's auxiliary. An auxiliary member greets patients and families at the door as a cordial hostess, rather than leaving them to find their way to an information desk for direction.

The atmosphere of the entire hospital is one of cordiality and friendliness and this atmosphere, created by the design and appearance of the structure, translates itself into the attitude of staff members and auxiliary members and, ultimately, the feeling of patients toward the hospital.

From Aug. 15, 1955, up to and including June 30, 1956, operating revenues of the hospital amounted to $834,628 and expenses amounted to $804,256. Although this may appear to be a small gain for a 10 month period, it does prove that a new institution can meet its own expenses, build up an inventory, and add necessary items of equipment.

During this time 4614 patients were admitted and 878 childbirths were recorded. The average length of stay was 4.6 days. The total census days of adults was 21,242. The medical and surgical floors, since January 1956, have maintained more than 90 per cent occupancy almost constantly, and it has been necessary to reserve beds on a priority basis for district residents. The maternity department, although slow in gaining popularity, is rapidly reaching the point where it, too, will show a high occupancy.

In January, use of the hospital reached new peaks, with as many as 70 patients in the surgical and medical floors. These floors have a total of 83 beds, in two-bed rooms, eliminating beds lost by private rooms and by necessity of separating types, ages and sexes of cases. The 70 patient occupancy on those floors exceeded practical usable capacity, and it was necessary to quarter some surgical patients in the maternity wing temporarily.

The hospital district, although it had the authority of the voters to assess a maximum of 20 cents per $100 of assessed valuation for maintenance and operations and during the first year of the bond payments an additional 12 cents per $100 of assessed valuation, absorbed both assessments for a total of 20 cents. During the hospital's first year of operation, it was not necessary to use any tax funds in the actual operation of the hospital.

The rapid acceptance by the community and the attending staff of Grossmont Hospital has proved the need for its existence and has made the board of directors and the doctors in the area realize that additional facilities must be added in the near future. It might be mentioned here that Grossmont Hospital has been planned for today as well as the future and has been termed the "expansible hospital." The district encompasses 700 square miles and it will be the responsibility of the district to provide health facilities as required, to meet the needs of the people.

Babies Draw Affection From "Mother Bank"

Sick babies need loving care even more than well ones, so this program of recruiting volunteer "mothers" among older women to give maternal care to the children six hours a day, five days a week, was inaugurated at Children's Memorial Hospital, Chicago, with good results

HENRY FINEBERG, M.D., and ELIZABETH C. JONES, M.D.

THE need for continuous mothering care for hospitalized young children has been recognized theoretically as well as clinically by all people concerned with the health and welfare of children. The mother knows her child needs her. The pediatrician has long prescribed Tender Loving Care. The frustration of the overworked pediatric nurse who can only give minimal routine attention to her small charges is apparent to those who work in the pediatric wards.

All this is known, yet supplying the need has posed a difficult problem. Additional nursing service is not only costly, but not available. Volunteer programs have not been successful because of the difficulty of getting volunteers to give more than one day at a time. To our knowledge, the volunteer has not been used as a mother substitute for a needy infant.

Condensed from a paper presented at the American Orthopsychiatric Association meeting, Chicago, 1957.

At the time this paper was prepared, Dr. Fineberg was director of the Child Guidance Clinic, Children's Memorial Hospital, Chicago. Dr. Jones is a fellow in child guidance at Children's Memorial Hospital.

An assistant director of nursing service uses a doll to instruct the volunteer mothers in the proper methods of feeding and giving bed care to the babies they will handle.

The psychiatrist, Dr. Fineberg, discusses the philosophy of the substitute mother program, and explains to the volunteers the psychiatric significance of the work they are to do.

NURSING STAFF APPRECIATES THE WORK OF SUBSTITUTE MOTHERS

SINCE these volunteers bring to us the essential attributes required to do this work, *i.e.* the interests and skills of a mother and grandmother, we need only to help them fit these skills into the hospital situation.

The recruitment of women willing to give this much time on a volunteer basis usually produces one, two, or at the most three women at a time; therefore, the orientation can be a highly individual affair.

A tour of the hospital is offered to give the volunteers an over-all feeling of the hospital. During the tour they are told a little of the origin, aims and development of the hospital. Some time is spent on the infant division where they will have most of their assignments. There they meet the head nurse and are given an opportunity to examine the physical setup of the division.

The actual instruction is carried out in a classroom where a patient unit has been set up and a doll is used for a patient. The teaching is accomplished by demonstration and discussion. The volunteer mother learns to feed, diaper and bathe the infant, using hospital supplies and equipment and to follow the same procedures that are used by the nurses.

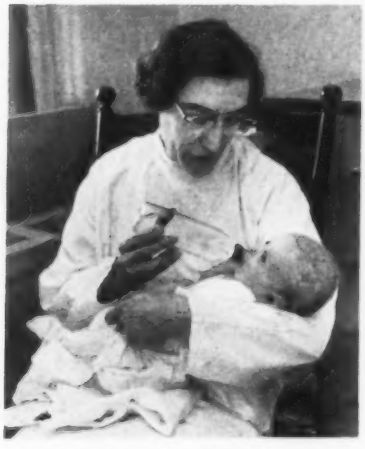
The most outstanding result of the Volunteer Mother program has been the response of the infant to the additional attention and handling given to him. Nurses on pediatric wards have always felt regret that the many demands of the service did not permit them enough time just to rock and cuddle the little ones. Over and over again we have seen the response of the weak, disinterested, chronically ill infant to this additional handling. It seems to help him establish contact with life again. His food becomes more tasty; his sleep deeper and more relaxed; his waking hours are times for smiles, coos and gurgles instead of kicks and cries. He seemingly has gained some strength to combat life.

The Volunteer Mothers have fitted easily into the ward situation. The nursing staff is appreciative of the contribution they are making toward the recovery of the little ones. The student nurses have at first been amazed that such a program exists, and then interested in its accomplishments.—CARMELITA LOUDERMAN, *assistant director of nursing service.*

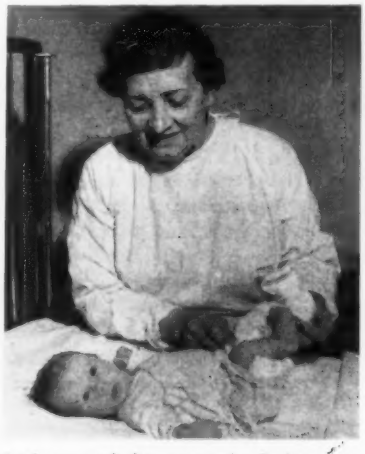
The stimulus for embarking on our project at Children's Memorial Hospital, Chicago, came while making hospital rounds. The frequent expressions of need for more care for the children from the professional staff and the need so eloquently expressed by the sick child lying isolated in his crib finally stirred us to action, and we inaugurated the "Mother Bank."

The Mother Bank has been organized around the use of older women recruited to give the children maternal care six hours daily, five days a week. They are assigned to one child for whom they are exclusively responsible for body care and feeding. Each volunteer remains with her charge for the duration of his hospital stay unless unusual illness keeps the child in the hospital too long, in which case the volunteer is permitted to take a respite.

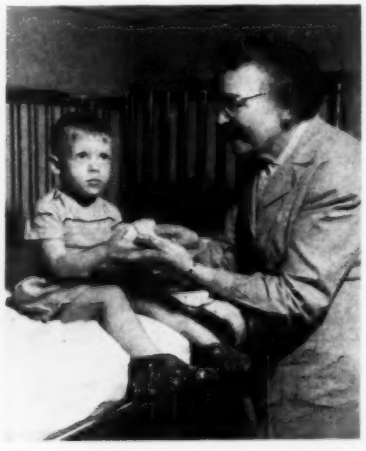
The care given the children by these volunteers is designed to substitute as much as possible for maternal care. The "mothers" are given a short orientation to hospital practices by the nursing service, and following this they are oriented to the emotional needs of the child. The latter is given by a



The old-fashioned rocking chair is one of the most useful pieces of equipment to a mother when she feeds the baby.



Bathing and diapering the babies are also part of the routine care given by the volunteers to their small charges.



Another volunteer is assigned to a 2 year old youngster—the oldest to be included in the hospital program.

psychiatrist in child guidance. The volunteers are instructed to give the patient a feeling of protective motherliness which may instill the "confident expectation" so necessary for security in development.

The volunteer is advised to hold and play with the child as much as possible during the hours that he is awake. When feeding him she is requested to hold him as she rocks gently in a rocker supplied for this purpose. Whereas the usual nursing practice allows only a limited time in which to feed a child because of the press of work, the women in the Mother Bank have the privilege of requesting food and keeping it for as long as they please. In this way we have found that the children who were feeding problems are much more easily fed and retain their food. The rocker, of course, is of considerable use in comforting and holding the child at other times. Bathing, diaper changing, and changing bedclothes are also performed by the volunteers.

CHILDREN WERE NEGLECTED

For the most part, the cases assigned to these women have been children under 18 months of age who were quite ill and withdrawn and usually had GI symptoms of vomiting, diarrhea or both, often accompanied by colic. They came from deprived backgrounds with a history of severe neglect. All children require an extension of maternal care while in the hospital; however, because of the limited number of women in the Mother Bank, we elected to use them on the most deprived group.

The results were remarkable in shortening hospital stay, reducing or eliminating all GI symptoms, and, in many instances, stimulating emotional responses in an infant who had been unresponsive previously because of little or no stimulation.

Something of considerable interest which we came upon first by chance, and then adopted as practice, was the choice of older women for these Mother Bank volunteers. At first we suggested that the only women to be used were women whose children were over 15 years of age. This was suggested because of obvious contagion problems and the recognition that younger children would need their mother at home. We found, however, that the only women who volunteered were women who were about old enough to be grandmothers, and we also noted other things of interest. First, the service given by these older women satisfied their quite normal desire to feel needed. This was enhanced by our giving them considerable administrative attention, such as meetings, occasional teas, and community publicity. In the second place, we noted with some relief that these "grandmothers" were willing to give devoted service to a child, but when the job was finished they had had, so to speak, enough. As is characteristic of older people, they do not make the libido investment in a child which one would expect from a younger woman in the childbearing age. One of the problems we had thought of was that of the traumatic separation of the deputy mother from her sick child. The normal response of the older women as described solved this problem.

It is of interest to note also that members of the pediatric nursing staff accepted the Mother Bank project quite willingly and with considerable good feeling since they had apparently felt the frustration resulting from seeing the child's need and being unable to fulfill it. The experience has been so gratifying generally throughout the hospital that we now have a waiting list requesting service from the Mother Bank.

A dramatic example of the service provided was afforded in the first case to which service was given. A six months' old child was admitted to Children's Memorial Hospital because of malnourishment, retarded development, regurgitation of food, withdrawn and unresponsive behavior, and a bad home situation.

The case history, as given by the mother, showed he was a premature baby weighing 2 pounds 5 ounces at birth. Delivery had been difficult. He remained at Cook County Hospital on the premature service for four months. When he was discharged he weighed 5 pounds 3 ounces. The mother had the child home two weeks when she returned him to the hospital because he was failing rapidly. During his two weeks he had been left in the care of an 8 year old girl, who also looked after four other children while the mother was employed. The mother had no knowledge of what the 8 year old did or did not do for the children. At the time of admission to Children's Memorial Hospital the child weighed 6 pounds 13 ounces and was six months old. His bone age was that of a newborn infant. He was not able to follow with his eyes. For the most part he held himself quite rigid. There were no facial responses to stimulation, no smiling responses, or for that matter any other noticeable responses to be seen except that he became more rigid when stimulated by holding or diapering. He refused to take solid foods.

When this child was admitted to Children's Memorial Hospital a woman from the Mother Bank was assigned to him. Her instructions, as previously described, were to give the child as much protective motherliness and care as possible. She was with the child from 9 a.m. to 4 p.m. for five days a week, playing with him and picking him up during the time he was awake. She was responsible for his bath and feeding in addition to changing his diapers and bedclothes as necessary. Within 24 hours the deputy mother reported that the child was beginning to relax in her care and showed some evidence of following her with his eyes. Within a week the youngster was rapidly gaining weight, smiling and showing considerable motor activity, particularly when handled by his volunteer mother. The patient was discharged in about two weeks, weighing 9 pounds 4 ounces, and showing active reciprocal responses to care and attention.

CHILD REFLECTS WARMTH

What was seen clearly in this child was the development of confident expectation, that is, expectation that the caretaker or mother figure will gratify the child's needs. It would appear that there was, despite the deprivation, a maturation of the inclination to responsiveness or reflective capacity which permitted a rapid response to maternal care and stimulation provided at a later date. It would seem that this proclivity only awaits the stimulus to evidence itself. We see the development in the child as being not only reflective or reciprocal, but like a reflective object in the sunlight that not only reflects the warmth but retains some of it. In addition to the effects on the child described, we were quite interested in the exhilarating and stimulating effect upon the mother substitute, who thrived on the responses obtained from the child. It is our opinion that with this point of view the conventional approach of a children's hospital must be revised to include specialized personnel who will direct their energies toward stimulating and improving a learning process in children who have been deprived of normal mothering.

First Define the Job, Then Set the Salary

This is the first of a series of articles on a method of establishing an equitable salary plan that will attract better personnel to give better patient care

JOHN H. HOLMGREN

THERE is a simple but effective method of taking the mystery out of developing job descriptions, evaluating duties performed, and placing "price tags" on jobs. The method is called job evaluation. It is used to rate jobs, not people. Applying job evaluation principles makes it possible to use a plan in the hospital which can be understood by most of the personnel. "Secret" pay practices become unnecessary; confidential salary policies no longer govern every personnel action. There is a reason behind salary administration.

GIVES ACCURATE MEASURE

Job evaluation is not a science but it can be used as an accurate measurement of jobs in the hospital. This measurement helps administration maintain the necessary balance in wages between what people do and the worth of their doing.

A job plan and a salary plan are related; one is necessary for the other. A study of jobs and a description of the duties of each help in the comparison of jobs and salaries in the hospital and among hospitals. One administrator may check salaries paid in other hospitals using his own job titles. This may lead to errors in salary comparison. There may be differences in the responsibilities of two jobs having the same title. One hospital's head nurse may be another's supervisor. The skilled maintenance engineer's duties in one institution may be no more than a semiskilled repairman in another.

A salary plan is needed in each hospital in order to maintain consistent pay practices. Variations in pay practices in a hospital lead to confusion and disturbed, discontented employes. A well planned salary schedule helps eliminate many personnel problems. A well conceived pay plan assists in keeping the stability of the working force.

The articles in this series have been developed on the basis that it is better to have a plan that is understood and accepted by the majority than one that few people understand and therefore reject.

Before procedure is discussed, certain principles of job evaluation and salary rating should be considered.

PRINCIPLES

There are several well defined principles which have become accepted as an intrinsic part of a successful job survey and the development of proper salary rates. These are as follows:

1. Give equal pay for equal work.
2. Rate the job, not the person.
3. Rate jobs on the differences in training, experience and responsibility required of each job.
4. Paying fewer people a fair wage is more economical than paying a larger number of people a lower than standard wage.
5. To be successful, a salary plan should be acceptable to the personnel paid under the plan.
6. It is better to be consistent in pay practices even if occasionally wrong than to be inconsistent often and right.

1. "Equal pay for equal work" is a basic principle of wage and salary administration.* It means that where two people are doing the same job having the same degree of responsibility, training and experience, their pay rate should be the same. This rate may either be one salary figure, called the single rate, or it may be a range of salary, called the rate range. If the two people are both receiving a single rate method of payment, their earnings do not vary. If a rate range for the job has been established with a minimum and a maximum spread, one may receive more than the other because of differences in ability or length of service, but *never* less than the minimum of the range and never more than the maximum of the same range. In other words, all nurse's aides come under the same nurse's aide rate of pay. The beginning rate for all general staff nurses should be the same (given the same approximate experience) and the "top" or maximum rate should not vary between nurses on this same job.

DIFFERENCE IS IN JOBS

2. Job rating reviews and determines the difference between jobs, not the difference in the way people perform those jobs. Perhaps there is no greater confusion than that caused by the mistaken idea that, when a job review is held, the review tells how

The author is business manager of St. Joseph Hospital, Wichita, Kan.

This is the first of a series of articles by Mr. Holmgren covering methods of determining fair salary rates for hospital personnel. The second article will appear in the August issue of this magazine.

*Wage administration refers to wage practices common to hourly paid employes; salary administration describes practices common to those employes (usually professional) paid on a monthly basis.

good the employe is on the job. In effect, a job evaluation review should determine the value of the job in relation to other jobs. The rating of personnel falls in a different category, employe rating or, as sometimes called, merit rating.

An example is found where a job is being studied and two employes are performing the same clerical duties of this job. The job involves the preparation of admissions forms, interviewing patients or relatives for credit determinations, and doing typing and accounts receivable work. If the job analyst or investigator is influenced by the fact that the first employe is more attractive and personable than the other, that the first employe is more articulate than the second and, in general, gives a better "first impression," the job analyst may decide that this is a Clerk A job (the first employe) and a Clerk B job (the second employe), assigning a higher salary rate range to the Clerk A job. In reality, both are performing the same duties as a desk audit of tasks would indicate. Both are Clerk A's or Clerk B's having been assigned the same degree of responsibility on the same job level. The manner in which the first employe does her work as compared to the second employe is a personal evaluation, not a job evaluation.

3. The duties of all jobs can be measured by such factors as degree of difficulty and degree of training and experience requirements. Thus, the greater the number of years of experience and education and the more responsibility a job has compared to other jobs, the higher the job is rated and the higher the salary paid.

Accordingly, in rating jobs, the factors remain the same; the way in which jobs differ in their value from the application of these factors determines their relative rank. For example, the job of director of nursing service may require four years of college on the factor "education," whereas that of a supervisor of nursing service may require three years of nurse training on the basis of the same factor, education; hence a lesser amount or degree of this factor is required.

4. Paying a lower than standard wage is likely to result in a lower caliber of personnel or lower work output or both. The result of a lower wage scale may mean the distribution of work among more people than necessary. The resulting labor costs may therefore be higher than is the case where pay is comparable to wages paid in other institutions or companies.

5. An extremely technical and accurate job rating plan may be clear and understandable to the administrator or job analyst responsible for it. But it will be harder to sell department heads and employes than the plan that is less technical and is simpler to explain. And the degree of acceptance of a plan is in a large measure responsible for the success or failure of salary administration.

6. It is believed by many that it is better to have consistent pay practices and to be wrong occasionally than to be inconsistent and create a disturbed group of employes. This principle assumes that by their very nature people will resent being treated differently than others where there is no basis for such difference. To cite an extreme example: If all employes in a hospital are prohibited from earning salary increases, they will accept that situation more readily than if the policy applies to selected departments or individuals only. This concept also applies to the misunderstanding which arises when a recently appointed employe learns that his beginning salary was less than that paid other employes on the same job and having the same qualifications.

In the light of the foregoing principles, what procedures are necessary to conduct a job survey and establish a hospital pay plan?

PROCEDURES

Following is a step-by-step outline of suggested procedures — to be used by the administrator, the job analyst or coordinator—to establish an acceptable job evaluation and an objective salary plan.

Step 1. Prepare for Study

Select the job analyst or coordinator responsible for completing the study.

Develop an outline or work schedule showing purpose of review, completion dates for work proposed, steps to be accomplished, final results expected. Distribute schedule to supervisors.

Call a meeting of supervisors and explain the purpose of the study; encourage their interest and participation. Make them feel that it will not only be a hospital plan, but it will also be their plan.

Explain the plan of study to employes, taking one department at a time, and obtain as much acceptance and understanding as possible at this point. Emphasize that there will be no reduction in pay or loss of benefits to any employe on the payroll. Request that supervisors participate in all meetings involving their department.

Step 2. Analyze Jobs

Prepare and distribute job questionnaires to all employes through their supervisors. Have supervisors answer questions that employes may have in completing the questionnaires. Help supervisors answer those questions.

Have supervisors collect and check job questionnaires 10 days from date of distribution. Check the duties shown on the questionnaires with each supervisor responsible for his employes' questionnaires.

Group all jobs by department and by occupation, *i.e.* all cooks, bakers and kitchen helpers under "dietary department." Do the same for the remainder of the questionnaires.

Develop organization charts of the hospital and each department showing job titles and lines of supervision over each job.

Assign tentative job titles to each questionnaire based on the job duties described by employes on their questionnaire, and the comments made by supervisors on all questionnaires, as well as on the organization charts and other information available.

Step 3. Develop Job Descriptions

Prepare a description of duties based on job questionnaires and organization charts. Use all "cook" questionnaires and all "general staff nurse" questionnaires, for example, to describe the common jobs for cook and for a general staff nurse.

Add the requirements in training, experience and responsibility necessary for each job description as the job specification.

Check job descriptions to be sure that they describe the difference between jobs in skill, training and experience and that the same terms have the same meanings in all job narrations pointing out these differences.

Check job descriptions with department heads and revise and redraft where necessary.

Check final copies with the administrator for approval.

Step 4. Rate Jobs and Develop Classification Plan

Rank key jobs first. Rank all jobs in each occupation next. Rank jobs in the order of their value based on

differences in education, experience and responsibility from the highest supervisory job to the lowest operational job in each occupation and department, using the key ranking as a guide.

Check and defend or revise rankings in discussions with department heads before obtaining the approval of the rating of jobs by the administrator.

Prepare final list of all jobs ranked by department and by total hospital ranking order, regardless of present salaries being paid. Note salary rates not in agreement with job ranking.

Step 5. Make Community Salary Survey

Arrange for appointments with hospital administrators, employment managers, clinic managers, and others employing hospital type personnel. Explain the purpose of your intended call.

Visit each person to obtain interhospital and intercompany information on actual salaries paid and hours worked in each job. Obtain fringe benefit information. Ensure comparability of community survey jobs by referring to job descriptions when discussing salaries with persons involved.

Convert all outside salary data to the same method of salary payment as used in the home hospital. Add compensation for free meals or room allowances. Develop average rates for all jobs.

Compare minimum hiring rates and average earned rates paid in other hospitals with those paid in the home hospital.

Step 6. Establish Salary Rates

Develop a new salary schedule based on the community salary survey and the job evaluation study.

Develop and distribute written procedures on salary and payment policies.

Explain salary plan to supervisors so that they can explain it to employes.

Install salary plan as of a predetermined date.

Monitor the job plan by reviewing all job consolidations or changes; review community salary rates yearly to check on adequacy of hospital's pay plan.

The subjects to be discussed in subsequent articles in this series have been divided into separate sections, each section representing a procedural step as outlined. These sections or steps may be studied by the administrator or job analyst and revised as necessary to fit a particular hospital's present administrative problem. Additional procedural steps may be added to this outline of procedure where it is believed that further emphasis is needed.

The important point stressed in this introductory article is that for every job, every salary paid, and every payment policy devised, the hospital administrator should be in a position to know the answer to the "How?" "What?" and "Why?" of everyday pay administration.

Dr. Rourke Predicts "Open Skies" Era of Inspection in Medical Care and Hospitals

CLEVELAND.—Only doctors can upgrade the quality of medical care, but the task of the hospital administrator is to motivate the hospital staff to self-improvement, Dr. Anthony J. J. Rourke, New York hospital consultant, said at the 42d annual convention of the Catholic Hospital Association of the United States and Canada here last month.

As the first speaker in a general program on appraisal of patient care, Dr. Rourke predicted a new era of "open skies" in medical care—"with tissue and record committees flying over every doctor's practice and looking down to see what is going on," as he explained it.

Hospital administrators must know and understand the technics for evaluating patient care, Dr. Rourke said, but he warned against actual participation in medical affairs by administrators.

"Your job is one of motivation, but you can only motivate when you know what you want to motivate," he explained.

"You must understand the nature of the physician, a rugged individual who is the product of a system of medical education that taught him to use his own eyes, his own ears, his own hands, and his own judgment. The greatness of medicine in our continent lies in the strong minded, strong willed physician who is able to make a decision. This we must never change. We must do the bending and veering as necessary."

The Rt. Rev. Msgr. A. C. Dalton, director of hospitals for the archdiocese of Boston, was named president-elect of the association at the annual business meeting. He will succeed the Rt. Rev. Msgr. F. M. J. Thornton of Sea Girt, N.J., who became president during the convention, which was attended by more than 5000 Catholic hospital representatives from the United States and Canada.

One of the liveliest sessions at the convention was a mock tissue committee meeting conducted for the Sisters by Dr. Robert S. Myers, assistant director of the American College of Surgeons, who played the part of a member of the hospital surgical staff and chairman of the tissue committee. Others taking part were Dr. William J. Lahey, St. Francis Hospital, Hartford, Conn.; Dr. Louis S. Smith, St. Paul's Hospital, Dallas, Tex., and Dr. William J. Reals, Wichita-St. Joseph Hospital, Wichita, Kan.

With Dr. Smith playing the rôle of the genial practitioner who has a tremendous practice but is not always scrupulously careful about the procedures he undertakes or the records he keeps, the group first demonstrated wrong methods of reviewing case histories and records at a tissue committee meeting, then discussed the same hypothetical cases taking a constructive, educational approach.

Among the suggestions made by members of the panel were:

1. The tissue committee should not

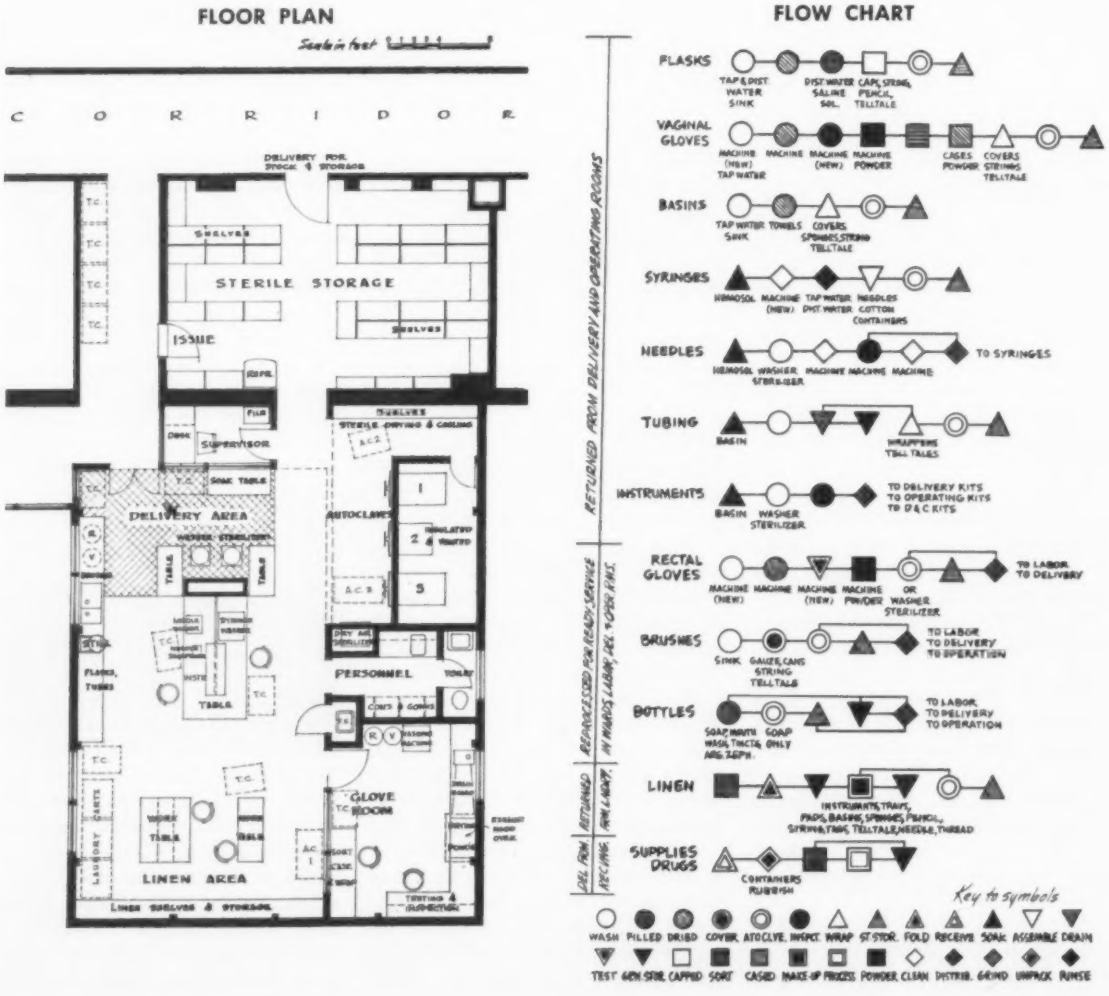
(*Continued on page* 144)

Officers of the Catholic Hospital Association are: secretary, Sister Ann Raymond, S.C.L., administrator of St. Vincent's Hospital, Billings, Mont., and president, Rt. Rev. Msgr. F.M.J. Thornton, Sea Girt, N.J. At right is Most Rev. Floyd L. Begin, S.T.D., J.C.D., auxiliary Bishop of Cleveland, who gave the opening address at the 42d annual meeting of the association.

Supplies Move Without Traffic Tangles

As flow chart, diagram and perspectives indicate, this central sterile supply department has been laid out so that supplies enter the department, are processed, and distributed with minimum cross traffic

Symbols in flow chart (below right) outline the way various types of equipment are processed through central sterile supply, in the areas shown in the floor plan (below left).



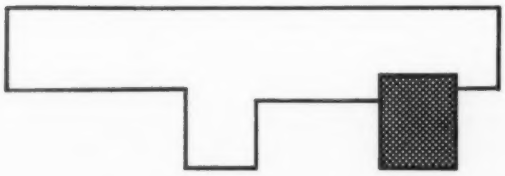
IN THE process of making additions and alterations to the Boston Lying-In Hospital last year, the architects, Edwin G. Johnson and John M. Whitcomb of Boston, made an intensive study of the proper design for a central supply department. Their working out of the problems of traffic flow, issuance and distribution of supplies, and cleaning and sterilizing technics are shown in the accompanying drawings and flow charts.

A basic problem was where to put the new central supply service when the building was remodeled. The solution: to build this area, the operating rooms and a new corridor on top of existing wings. The plan of the remodeled delivery floor shows the relation of central supply to other services.

The hospital purchases all parenteral and intravenous solutions so no space had to be allocated to solution manufacturing, the architects explain. Flasks of saline solution and distilled water are filled at the still and then autoclaved.

A routine has been established for the cleaning of needles to minimize the danger of infection to those who handle them. They are put in a wire basket, after a preliminary soaking, then run through the washer-sterilizer before being cleaned in the regular needle cleaning machine.

Perspective of glove room shows testing and inspection area at right, exhaust hood over drying space at back.



Left, shaded area shows relationship of central sterile supply to rest of delivery corridor. In perspective below, autoclave is at left; washer and sterilizer are in center, with syringe and needle washers and needle sharpener directly behind. Linen storage area and work table are at the rear.

What Hospitals Do About Employes' Health

Thirty-six hospitals answer a questionnaire study of their policies and present methods of providing health service for their employes and staff members

THERESA SELCOE and E. W. JOACHIM

BECAUSE it has long been assumed that employe health programs are either loosely organized or continually in a state of flux, they have not been subject to intensive investigation through the questionnaire form. In attempting a survey of health programs for employes, the research committee of the Hospital Personnel Association recognized the difficulties and so prepared a questionnaire which allowed considerable latitude in form of reply. Therefore, a full statistical analysis is impossible. Where answers to questions could not be tabulated, they are summarized in the text of the article. Statistical tabulations of the remaining questions appear in the accompanying tables.

Questionnaires were submitted to the 60 members of H.P.A. and 36 hospitals replied. Twenty-eight of these were in the five New York boroughs, and eight were in New Jersey. Two of the 36 hospitals replying were U.S. Public Health institutions, and one was a TB hospital.

The questionnaire was in two parts: the first for those who have no formal health programs for staff members; the second for those who have. The first section consisted of four questions relating to procedures for accidents and illness on the job, admission of employes as inpatients, requests for extensive diagnostic services or treatment, and charges for special services.

Two hospitals completed the first part only—one a New Jersey hospital

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2A—TO WHOM ARE PHYSICAL EXAMINATIONS GIVEN?

	Total Replies	Do Give	Do Not Give
Permanent Full-Time Employes.....	32	31	1
Temporary Full-Time or Part-Time Employes.....	30	23	7
Permanent RN's.....	30	29	1

2B—ARE EXAMINATIONS GIVEN BEFORE OR AFTER EMPLOYE STARTS WORK?

	Before	After	Before, After	Not Spec.
Permanent Full-Time Employes.....	24	4	2	1
Temporary Full-Time or Part-Time Employes.....	20	1	1	1
Permanent RN's.....	20	5	3	1

2C—ARE FORMER EMPLOYES REEXAMINED? AFTER WHAT LAPSE OF TIME?

Yes	No	1 Month or More	2 Months or More	3 Months or More	6 Months or More	12 Months or More	Time Limit Not Specified
31	0	3	2	4	5	4	13

2D—IS REEXAMINATION REQUIRED WHEN EMPLOYE RETURNS FROM SICK OR MATERNITY LEAVE?

Yes	No	Optional
21	11	1

3A—WHAT TESTS ARE ROUTINELY INCLUDED IN PHYSICAL EXAMINATION OF EMPLOYES?

Total Replies	Chest X-Ray	CBC	Urin.	Serology	EKG	BMR	Paras. & Ovum	Blood Type	HGB.	Throat Culture	Rh Factor	Tuber-culin	Gen'l Phys.
31	31	13(+4)	29	29(+1)	2	(1)	2(+22)	2	2	1	1	1	31

Figures in parentheses include additional hospitals providing these services when indicated by past history, examination, at employe's request, or routinely for specific departments.

of 650 employes (which, we understand, is in the process now of developing a formal health program) and the other, a Long Island hospital with approximately 370 employes. In each of these hospitals, on-the-job accidents and illness are handled through their emergency room; tests and special service requests seem to be accepted indiscriminately without review; charges for special services are made at clinic rates, in one case, and individually considered, ". . . based on position, length of service and so on," in the other.

Thirty-three hospitals, which completed the second part, were divided as to bed capacity and total employes as follows: five have fewer than 200 beds; 19 have between 200 and 499 beds; seven have between 500 and 1000 beds, and two have more than 1000 beds. Twelve of these 33 hospitals have between 200 and 499 employes; 13 employ between 500 and 599 persons; six have between 1000 and 1999 staff members, and two hospitals employ more than 2000 persons.

And there is the 36th respondent, whose comment should be quoted, particularly in view of the fact that only a note and not a questionnaire was returned: "Frankly I feel that your survey will have fewer fuzzy edges if you forget our questionnaire. Our policy is confusing even to me."

DRAWS TERSE REPLIES

As for the second part of the questionnaire, for those with some formal health program, *Question 1* drew some surprisingly terse replies. The question read: "State briefly the official policies under which your health program operates."

Several of these replies are quoted: "To provide preemployment physicals . . ."; "All paid employes are included . . ."; "We make highly integrated use of outpatient and emergency room services," and ". . . all employes are free to use its services at any time. . . ."

On the other hand, several policies were outlined more fully, *i.e.* "A positive health program emphasizes the prevention of diseases and accidents and the maintenance of optimum health." ". . . preventive medicine in order to keep employes on the job.' "

Question 4 asked about annual or semiannual reexaminations for staff, and, if the examination was partial, the tests included. Twelve hospitals give full reexaminations to all staff; two for dietary staff only; one gives

3B—ROUTINELY INCLUDED IN GENERAL PHYSICAL:

Hospitals Providing	Internal Exam.	Visual Acuity	Aural Acuity	Color Blindness
31	5	12	8	1

5—WHO CONDUCTS THE GENERAL PHYSICAL EXAMINATION?

Total Replies	Paid Physician	House Staff	Attending Physician	Paid Physician for Nurses, House Staff for Others
32	19	7	5	1

6—HOW OFTEN DO PHYSICIANS SCHEDULE EMPLOYE EXAMINATIONS?

Total Replies	Daily	3 Times Weekly	Twice Weekly	Once Weekly	Bi-Weekly	On Call
31*	20	3	2	3	1	2

*The time given by the physician for each period scheduled ranged from one to four hours. In no hospital polled did a physician spend 40 hours a week in the health service.

7—WHAT FACILITIES ARE PROVIDED FOR EMERGENCY CARE TO EMPLOYES WHEN HEALTH SERVICE AND/OR PHYSICIAN ARE NOT AVAILABLE?

Total Replies	Emergency Room or Accident Ward	Outpatient Department	Nursing Office or Emergency Room or Outpatient Department
29	23	4	2

8—AVERAGE NUMBER OF SICK VISITS TO HEALTH SERVICE PER EMPLOYE PER YEAR

Total Replies	Visits per Employe per Year						
	8	5	4	3	2	1	Less Than 1
24	1	2	4	6	3	4	4

10—WHO MAKES FINAL DECISION REGARDING EMPLOYMENT IF EMPLOYE OR APPLICANT MIGHT BE CONSIDERED HEALTH RISK?

Total Replies	Hospital Director or Assistant	Health Physician	Personnel Director	Combination of These
32	9*	8	7	8

*Usually has power to overrule.

12—WHAT PERCENTAGE OF APPLICANTS OR EMPLOYES FAIL PHYSICAL EXAMINATIONS?

Total Replies	3% or Less	5% to 7.5%	10%
28	22	3	3

14—WHAT IS AVERAGE COST OF HEALTH SERVICE PER EMPLOYE PER YEAR* (Salaries Only for Health Service Staffs)

Total Replies	$3 or Less per Employe per Year	$3-$6	$6-$9	$9-$12	$12-$15	$25
20	2	6	4	4	3	1

*The committee divided the total estimated annual cost of staffing each health service by the average number of employes at each hospital.

repeat chest x-rays only for all staff; three more give only repeat chest x-rays to dietary staff. Dietary staffs in two hospitals receive repeat urines, and, in three hospitals, repeat serologies. One does repeat CBC's on staff working with radioactive materials.

Question 8 asked for estimates of annual visits through the health service for new employes' physical examinations and for sick calls. There were 24 replies which could be tallied. Of these, seven had a ratio of usage of 70 per cent or more—that is, the number of examinations for new employes averaged approximately 70 per cent or more of the total number of employes on the staff. Part 2 of this question (sick calls) will be found in the accompanying tables.

In *Question 9*, hospitals were asked to list specific physical findings which would eliminate applicants or employes from their staffs. The following replies were tallied in order of frequency mentioned: hernias, epilepsy, all types of heart abnormalities, tuberculosis, venereal diseases, psychoses and other mental aberrations, diabetes, visual deficiencies, alcoholism, cancer, drug addiction, obesity, hookworm, defective tonsils, pregnancy, arthritis, skeletal and muscular defects, bad teeth and amputations.

Answers to *Question 11*, "How is the problem of 'accident-proneness' handled in your organization," were greatly diversified when they were given at all. This question proved impossible to tabulate, but several quotations will perhaps indicate trends: "'Accident-proneness' condition is drawn to the attention of the department head." "We endeavor to correct . . . through medical treatment . . . or consultation. If these measures fail, the employe would have to be released." "Generally try to make provisions to transfer to another type of position." "Accident-prone employes are reviewed by consulting with personnel director and department head with possible solution arising from discussion." "Safety committee notifies supervisor of accident-prone employe and supervisor is responsible for discussing problem with employe. . . ."

Interestingly enough, the emphasis seems to be placed on personal conferences with the accident-prone employe—and, more rarely, on a review of possible physical disabilities such as defective eyesight or hearing.

Question 13 dealt with types of personnel regularly assigned to the health service, in addition to the health physician, and their average weekly hours. Replies to the question by 28 hospitals generally showed that most hospitals have some help in addition to the health physician; the additional staff may be paid separately but more often seem to have other full-time or part-time regular assignments. Included in the hospitals replying are two institutions with rather large—and costly—staffs: One employs a nurse, secretary, clerk-typist and medical typist, each on a 40 hour basis, and this hospital's health service payroll totals $20,500 annually. The second hospital with an extensive staff has seven full-time assistants, including two nurses, three clerks, one aide, and a secretary; the total payroll is $50,000 annually.

Usage of these staffs ranged in time from a full 40 hours weekly (most frequently for nurses) down to two, three or four hours weekly (usually for clerks and aides). Question 13 is another that defied accurate tabulation or interpretation.

Question 16 asked what procedure is followed regarding medical approval after sick leave. Twenty-two hospitals replied that approval was required; three others indicated that no approval is required, and two stated that they have "no policy." Of the 22 with some form of approval required, eight refer the employe to health service; two require a doctor's note, and two ask for either a doctor's note or approval from the employe health service physician. Five require some form of medical approval at the request of the department head, and five require medical approval following a specified illness or a specified length of absence from work in the hospital.

Question 17—parts (a), (b), and (c)—asked: "(a) Are referrals by an employe's personal (nonstaff) physi-

(*Continued on Page* 134)

15—IN WHAT DEPARTMENT ARE EMPLOYE HEALTH RECORDS KEPT?

	Health Service Offices	Outpatient Clinic	Medical Record Department	Personnel Office	Business Office
Present Employes	16	7	5	3	1
Terminated Employes	10	4	4	9	1

19—DO YOU PROVIDE PREMARITAL BLOOD TESTS?

	Do Not Provide	Free	Do Provide Charge	Total
For Employe	7	18	7*	25
For Fiancé	18	6	7*	13

*Of the seven hospitals that charge employes, two give a 50 per cent discount on regular rates and five did not specify the amount. Of the seven that charge the employe's fiancé, two charge full rates, two charge $3 for the test, one charges $5, and two failed to specify the amount.

25—DOES HOSPITAL HAVE GROUP HEALTH INSURANCE FOR STAFF?

Total Providing		Employer Pays in Full	Employe Pays in Full	Cost Shared by Employer, Employe	No System Specified
Blue Cross	30	10	17	3	
Blue Shield	23		22		1
Perth Amboy Plan	1		1		
Blue Shield (Surgical Only)	1		1		

26—WHAT IS PERSONNEL OFFICER'S RELATIONSHIP TO HEALTH SERVICE?

Total Replies	Personnel Supervises	Personnel Consults	Separate Departments
32	13	11	8

The Five Sides of the Nursing Problem

Patients, doctors, nurses, educators and administrators all have problems—and must help find answers—in nursing

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THE greatest problem facing us today in nursing is the shortage of nurses, and the increasingly poor nursing care resulting because there are not enough nurses to do what needs to be done. Many causes can be cited as contributing to the nursing shortage:

1. There has been a tremendous increase in the number of hospital beds, resulting from the countrywide hospital expansion program.

2. Industry is providing new openings for nurses almost daily.

3. Public health nursing and school nursing are expanding their spheres of influence and need hundreds, even thousands, of additional nurses.

4. The shift to a 40 hour week in most hospitals has added a minimum of 20 per cent to the number of staff nurses needed; in hospitals where nurses formerly worked more than 48 hours a week, this percentage is even greater.

5. Nurses are now being asked to do many things that doctors formerly did; this means that more nurses are needed to care for the same number of patients.

6. Nursing itself has become much more complex than it formerly was, and more nursing time is taken up with intricate and complicated medical procedures and treatments.

7. Changes in medical practice, such as the administration of antibiotic drugs by syringe in place of pills formerly given by mouth, have multiplied manyfold the time it takes a nurse to give her medications.

8. The armed forces are employing many thousands of nurses who were formerly available for hospital work.

9. Large numbers of nurses are now enrolled in universities, working toward their degrees.

10. The percentage of nurses who are married, and consequently eligible to retire from nursing for family reasons, has changed from one out of every five in 1930 to almost four out of every five in 1956. Pregnancies, family responsibilities, and the assignment of their husbands to other towns have caused many of these married nurses to be unavailable for active duty. When they are able to nurse, too often it is Monday through Friday, daytime shift only.

All these factors have either produced an increased need for nurses or resulted in fewer available nurses to meet the needs. It was during this time, also, that nursing education leaders chose to make a determined countrywide drive to raise standards of nursing education. This resulted in a marked withdrawal of the services of student nurses from patients during their training period, and has made it impossible for hospitals with school affiliations to give adequate nursing care to their patients without employing many more graduate nurses than formerly.

Aside from the nursing shortage, there are other problems facing those responsible for providing nursing care. There is the increasing *cost* of providing nursing care. There is

the increasing cost of nursing education. And there is the rapidly widening gulf between those nurses responsible for "front line" nursing—actual daily contact with patients—on the one hand, and, on the other hand, the many nurse educators who are getting further and further away from the bedside care of patients, and further and further away, incidentally, from the "service ideal" of nursing care.

Let us now place ourselves for a moment in each case in the position of the patient, the doctor, the nurse, the nurse educator, and the hospital administrator, and try to capture the perspective which each of these individuals brings to bear on the problems just described.

Then let us propose certain courses of action and suggest certain changes in attitudes which, if they could be accomplished, would in my opinion bring us nearer to achieving the better nursing care and more nursing care which we all want. Let us see what help we might expect from each of the different groups involved. In the following pages, the problems are described in each case in light-face type, and the desired attitudes and actions in bold-face.

The Patient Wants All the Necessary Services

THE patient wants as much nursing care as he feels he needs. Some patients are more demanding than others, but primarily they all want the necessary services, performed cheerfully and willingly and within a short time after they ask for them. Patients are interested in the cost of their nursing care only indirectly, because it is usually lumped into a daily care charge on their bills that includes room and board also. Although many of them have real difficulty in meeting these bills, approximately one-third of which represents the nursing care they receive, it is safe to assume that most patients are willing to pay what it costs to provide them with good nursing care. To the patient, good nursing care means not only *good* professional care but also *enough* professional care. No matter how skilled the morning nurse, if the afternoon nurse does not answer the light quickly enough, patients begin with all sincerity to think they are not getting good nursing care.

The patient takes nursing education for granted, usually knowing little and caring less about the philosophies which influence this discipline. He likes student nurses instinctively as individuals, and regrets that it is necessary to have several different students minister to his wants in succession rather than having just one student assigned to his over-all care day after day.

THE patient is entirely right in expecting good nursing care and enough nursing care. Many patients, however, will expect more than their share of attention and do not realize that many of the luxuries of nursing care (such as the alcohol back rub two or three times a day, for example) have pretty well gone by the board. Patients must be educated to share the available nurse power with each other, particularly with their sicker companions, recognizing that the more critically ill and injured patients have a priority on the time and attention of the overburdened floor staff.

Patients must also be continuously educated as to the reasons for the increasing cost of hospital care, including nursing care. They must be educated to the frame of mind where they are not only willing, but glad, to have those who care for them paid adequate salaries. The average patient who is sick or injured tends to feel sorry for himself and feels that somebody ought to take care of him. He does not really, however, in his sober moments, expect something for nothing. He must be taught that the paying of decent salaries to nurses will involve some increase in his hospital costs, and this he should be willing to cheerfully accept.

The Physician Expects Somebody to Do Something

THE physician wants just about the same thing that the patient wants. He knows there is a nursing shortage, doesn't know what caused it, doesn't know how to cure it, but expects somebody else to do something about it. He is better able than the patient to judge the quality of the professional care rendered and is therefore more critical than the patient when quality is not up to standard. He is not concerned at all with the niceties of nursing, the little things that can be lumped under the heading of T.L.C. He has no responsibility for paying for the nursing care and consequently is not in a position to balance the cost against the service rendered. He does not want to become involved in hospital economics, or nursing education philosophies, but he does know what is best for his patients in the way of specific nursing care and keeps constant pressure on hospital administration to provide it, regardless of cost.

The average physician looks back with nostalgia to the time when nurses were much more subservient to his wishes than they are today. He is surprisingly open-minded on this in most cases, however, recognizing that conditions have changed, and that nursing is much more complex than it was 15 or 20 years ago. But he does have one great inconsistency. He continually asks and expects the nurses on the floor, whether student or graduate, to take on responsibilities which until recently were solely the prerogative of the physician, and yet in the same breath he complains bitterly that nurses are trying to become "doctorettes" and are no longer interested in providing bedside care to patients.

THE physician must realize that he can't have his cake and eat it too. If he wants nurses to do intravenous infusions, blood transfusions, intramuscular

injections, and many other procedures formerly in the domain of the intern or the attending physician, then he must also realize that these same nurses will not have as much time to give to bedside care as they had formerly.

The physician must adapt himself to the nursing shortage by bearing in mind, when he writes orders on a particular ward, that the nursing staff can only do so much in an eight-hour shift. He should not write orders that are impossible for the available nursing personnel to carry out at any given time. The physician should not expect as much personal attention from the nurses as he used to demand—such as writing his orders and requisitions for him, and running his errands. He must realize that even if the head nurse would like to make rounds with every doctor on the floor, she cannot always do this and at the same time remain in control of the various activities being carried out by the different personnel on the floor reporting to her. He must recognize that the "administrative nurse" is just as important to the efficient management of the ward and the care of his patients as the "bedside nurse" who actually gives them most of their personalized care.

The Nurse Is a Professional Trying to Do a Job

THE nurse is a highly trained, well educated, professional person trying to do a job. In most instances she has been carefully taught, and she knows what good nursing care is. She is usually happy if she can work under conditions where she can provide good nursing care for her patients. In addition, she is rightfully interested in salary, vacations, working conditions, and general personnel policies. She has two parallel motivations, both of which are thoroughly legitimate, and she can become quite unhappy if these conflict, instead of running harmoniously side by side in the same direction. One of these is her deep humanitarian impulse to give of herself in the service of her fellow man. The other is her basic need to receive adequate compensation for the services she renders.

Probably the happiest nurses—and the happiest people, whether nurses or not—are those who have completely dedicated their lives to serve in one of the many Orders which offer this type of opportunity. In their case there is no possibility of conflict between the two motivations. For the nurse who is dependent on her income for her livelihood, however, it is proper for her to be concerned about personnel policies. Although progress may seem slow at times, I believe the public is gradually becoming more aware of the dollar value of nurses' services. Most people when they become sick have a tendency to revert to childish dependence, and to expect subconsciously the same kind of attention that was rendered them by their mothers when they were young. Patients are now beginning to awaken to the fact that they cannot expect this kind of service unless they are willing to pay a fair price for it.

What does the average nurse think of the nursing shortage?

Most nurses are affected by the shortage and would welcome additional nurses on the staff if they were available, not only to lighten the daily burden, but also to share the less desirable evening, night and week-end assignments. The average nurse looks upon the nursing shortage as a dark cloud on the horizon—but she can console herself that it has a very realistic silver lining, in that as long as it continues she will always be sure of a job, regardless of economic conditions.

Looking at the current trends in nursing education, the average nurse, having worked hard herself as a student nurse, might be excused for viewing without much enthusiasm the shift toward a shorter work week for nurse students, reduced hours of bedside care, and the lessened responsibility which is characteristic of modern trends in nursing education. She is concerned because she senses that nurse educators are inclined to downgrade her years of practical experience in favor of the modern curriculum where lecture, classroom and laboratory play such a prominent part. She is glad to have students on her ward, however, takes pride in helping them learn nursing, and gladly delegates to them as much of her work as she can reasonably get away with. If she is unmarried, she may find herself assigned to more evening, night and week-end duty than she likes, because the married nurse is refusing to work these unpopular shifts and student nurses are being assigned to them less and less frequently.

THE nurse must develop a broad understanding of all of the factors which bear upon hospital policies and the conditions under which she works. She need not be content to accept a salary less than other nurses in the city or in the state are receiving, yet the tactics used by labor unions for getting more money are inherently obnoxious to most nurses. Nurses must develop ways and means of making their voices heard in a professional manner, as opposed to a political pressure manner. The level of nurses' salaries is gradually but steadily being raised throughout the country, and if the nurses can be patient they will find this trend will continue and probably accelerate.

Nurses must never lose sight of the humanitarian nature of their work, however. The nurse who is not dedicated to her task of bringing comfort to sick people is likely to be an unhappy and disgruntled nurse. Nurses must resist the tendency to look upon their jobs solely as career opportunities or opportunities for advancement, and must cling steadfastly to the ideal of the life of service. I believe that if they will do this, all good things will come to them. But if nurses lose sight of the service ideal, then they are headed toward frustration and dissatisfaction, even if temporarily they would seem to be better off economically. It is my hope and prediction that both goals are attainable at one and the same time—the life of service *and* good working conditions—and this is what I would urge all nurses to set their sights to achieve.

(Continued on Next Page)

The Nurse Educator Needs to Consider Costs, Too

THERE are varying points of view among nurses in this category:

1. *Nurse educators who are also responsible for providing nursing care for the sick in hospitals today.* In the great majority of cases a single individual heads the nursing service and nursing education in a hospital. These nurses have a difficult, and sometimes almost impossible, task to perform. The needs of the hospital patient for adequate nursing care are frequently in apparently direct conflict with the educational principles with which the nurse has been indoctrinated. How far, and when, should she compromise her educational principles, or the educational program mapped out for her students, in order to try to meet the very real and pressing demands of nursing service during a particular day, hour or week? If she hews strictly to the educational line and refuses to compromise, how can she slough off her responsibility to the patients? If, on the other hand, she yields to the service needs, she may be burdened with frustrations because of the necessity for compromising her educational principles. Such a combined responsibility could possibly be handled adequately in a hospital where nursing service needs could be taken care of without relying on student nurses' services. But where is such a hospital today?

If it is predictable, as I believe it is, that the present nursing shortage is going to get worse rather than better, how are these conflicts going to be resolved? The hospital administrator, the medical staff, and the patients can bring tremendous pressure to bear to the end that service needs may be met. On the other hand, state accrediting agencies, national accreditation agencies, and professional groups and societies can also bring tremendous pressure to bear for the strict upholding of current educational standards. The nurse who holds the dual position is caught in the middle.

Nurse educators who also have responsibility for nursing service usually become reasonably cost conscious, recognizing the hospital administrator's problems in this area because of the broadened point of view which comes from their dual position. The greatest danger they face is in the pressures that tend to swing their outlook and their efforts preponderantly toward the educational side. This comes about because no one else in the hospital has nursing education as her primary field of concern except the director of the school and her faculty. Nursing service needs, on the other hand, will seem to her to be adequately represented by her assistant directors of nursing service, the medical staff, and the hospital administrator. Yet, in identifying herself preponderantly with the school, and making her decisions in favor of the school, more often than not she is fighting a losing battle in the long run, because service needs are going to have to be met. She would lead a much happier life if she allowed her sympathies to go in the other direction. But boards of nurse examiners, professional nurse educators, and the various accrediting agencies will not allow her to accept peacefully such an otherwise rational philosophy. The hospital administrator and the assistant directors in charge of nursing service, being confronted with an acute, real-life situation, with the lives and welfare of the patients literally at stake, almost invariably take the attitude that patient needs must come first—when there is a conflict. A nurse educator who cannot accept this decision and live philosophically with it without necessarily sacrificing her ideals or principles is going to be a very unhappy person, and may eventually find her position intolerable.

2. *Nurse educators who are removed from contact with the patient.* These nurse educators have no responsibility for service to the patient or cost to the patient. Their one concern is the *quality* of the educational program for which they are responsible. They do not even have to worry too much about the cost of their programs to the students. Because they are not responsible for, and only theoretically concerned with, the *quantity* of nurses available, nurse educators in collegiate programs do not seek large classes, and do not even want large classes in most cases. It is obviously easier to carry out a strong educational program if the ratio of faculty to students is high, and as long as students are willing to pay the tuition necessary to support such programs there is no reason for these collegiate nurse educators to strive for anything different.

It is the isolation of these nurse educators from the responsibility for the *numbers* of nurses graduating, and for the *cost* of the nursing program to affiliated hospitals, that is causing so much concern.

NURSE educators must abandon their dream of taking all nursing education out from under the wing of the hospital and establishing it under the supervision of educational institutions such as colleges, junior colleges, and universities. They must come to realize that the hospital itself is an educational institution par excellence, specifically for the education of doctors and nurses but also including many of the paramedical specialties.

Nurse educators should be more responsive to the needs of the patients who are being used in the educational process. They should inculcate in their students ideals, attitudes and motivations based on the service concept, recognizing that this is basic to both medicine and nursing, and once lost is difficult if not impossible to regain.

Nurse educators should become more responsive to the *cost* of nurse education and should think twice before pursuing the present trend toward shifting this cost to the parents of the student or to government agencies. It is perfectly possible for a student nurse, in a well conceived program, to earn all or a large part of her tuition by the services she renders to patients in the hospital, without any sacrifice of the educational values involved. Furthermore, many good potential candidates for nursing schools are being lost to nursing because of increased tuitions. The "earn while you learn" philosophy is deeply embedded in our American background, and it is disturbing to see it being deliberately abandoned by the proponents of modern nursing education. Those who

believe in it should not be afraid to speak up and make their voices heard.

It is becoming more and more apparent that some nurse educators at the top level who are guiding the policies of nurse education are concerned primarily with the *status of nursing education as a profession,* and seem to be not enough concerned with the country's need for more nurses. As these individuals are largely responsible for the instruction of all nurse educators, it is obvious that they can wield a tremendous influence on the attitudes with which nursing school faculties approach their work.

In trying to correct the weaknesses in some of our three-year schools of nursing, these nurse educators sometimes appear willing to kill the patients as long as they cure the infection. It seems to hospital directors that a well developed pattern is unfolding which will eventually result in the elimination of all three-year schools of nursing. This will be accomplished by closing the weaker schools, and by using the accreditation program to upgrade the better schools to the collegiate level. The only possible result of this movement will be the production of fewer and fewer nurses each year. Most hospital administrators do not think that a time of great shortage is a good time to raise standards beyond necessary safe levels.

There is another trend in nursing education which is beginning to receive some impetus now—for the creation of schools of nursing in two-year associate degree colleges. In these programs bedside practice is almost entirely eliminated, the greater portion of the two years being allotted to classroom, laboratory and theoretical teaching. Even when students do get to the bedside they are given little or no responsibility for patient care and thus have no opportunity to attain proficiency in any of the nursing arts. Nurse educators expect that these two-year graduates will be employed by hospitals on exactly the same basis as graduates of three-year schools, although it is perfectly obvious they will require many months of supervised training on the wards before they can properly be given the same responsibilities. Yet hospitals are supposed to pay them the same salary from the beginning.

Nurse educators in the four-year collegiate schools seem to be working toward a similar goal—reducing the hours of practice for the student nurse to the vanishing point.

Many collegiate nursing schools are now approaching a 24 hour practice week for student nurses, with no indication that the demand for reduced hours will not continue unabated. Student assignments for evenings, nights, week ends and holidays are being eliminated as rapidly as possible. In many cases not even lip service is paid to the "service ideal," but students are encouraged to feel that their hospital experience is solely for their intellectual benefit, and that it is an imposition to expect them to render any service to the patients from whom they are learning the art of nursing. Thus attitudes are created in the minds of the students, at their most impressionable age—attitudes which militate against the student's accepting the adult responsibilities of general staff duty when she has graduated.

The Hospital Administrator—Man in the Middle

THE hospital administrator is the world's greatest middleman. Conscientious hospital administrators are always in the middle in this respect—they are constantly trying to strike a happy balance, keeping the patient's cost as low as possible for the benefit of the patient, and yet paying in salaries and wages a fair rate of return to the many different persons on the hospital payroll who are providing those services. The administrator is constantly in the middle because patients complain about the increased cost of hospital care, on the one hand, and at the same time all hospital employes complain that they are not being paid enough. The hospital administrator can obviously satisfy one group *only at the expense of the other,* and it frequently takes the judgment of Solomon to decide what is the fairest thing to do in a given case.

The hospital administrator has full and final responsibility for providing professionally competent nursing care, an adequate amount of nursing care, and reasonably priced nursing care, to the patient. He cannot dodge this responsibility, nor can he share it with anyone else. He is deeply concerned, therefore, with all three of the factors which go to make up nursing care—quality, quantity and cost. He must continuously balance these factors and weigh them against each other in order to ensure that he does not fall below safe standards of quality and quantity, and that the cost to the patient does not skyrocket out of control.

The hospital administrator is forced to concern himself with nursing education, not because he is an expert in this field or because he is primarily interested in the field, but because the programs offered by schools of nursing seem to him to have a direct bearing on the nursing shortage and the costs of operating a school of nursing. In the field of nursing education, therefore, the hospital administrator has become deeply concerned about the *quantity* of student nurses enrolled and graduating, the *quality* of the educational discipline offered, the *cost* of the program to the hospital and hence to the patient. He is also concerned with the question of whether hospitals shall give up all control over nursing education to educational institutions having no responsibility either for supplying an adequate number of nurses, or for the cost to the hospital of the educational program offered.

The hospital administrator is concerned about the nursing abilities of the new graduates he employs, and whether they are prepared to take the responsibility staff nurses must assume in this day of team nursing, with the graduate spending more and more time supervising work done by others on the team.

The hospital administrator, therefore, is forced by circumstances to take the broadest view of any group connected with nursing. He must be alert to the patient's needs, he must be able to satisfy the doctor's demands, he must understand the desire of nurse educators

to graduate well trained nurses, and he must sympathize with the legitimate requirements of staff nurses for adequate salaries and perquisites. The hospital administrator can obviously not afford to take sides and favor one group over the other. It is his earnest desire to meet the legitimate needs and demands of patient, doctor, nurse, and nurse educator. When circumstances find him in what seems to be a difference of opinion, or even a conflict, with any one of these groups, it can be only because he sees that group upsetting the essential balance which must exist at all times in the hospital between the members of these different groups if the hospital is to fulfill its highest function in the community.

LASTLY, we come to the question of what hospital administrators can do to relieve the nursing shortage and help steer nursing education into the realms of reasonableness and responsibility. There are a few things that hospital administrators can do by themselves. However, there are a number of things that might be done to solve the nursing shortage that involve action by other groups, or by combinations of groups. The following program is therefore considerably broader than one which could be accomplished by hospital administrators acting as a single unit.

1. First of all, hospital administrators should make sure they pay their nurses adequate salaries. Although money is not a primary factor in the decision of most girls to go into nursing, there is no question that the ultimate salary obtainable does play some part. If nursing salaries are too far out of line with what girls can expect to earn in other fields of endeavor, they may be discouraged from taking up nursing as their profession. Hospital administrators are faced with the problem, however, that nursing salaries constitute the largest single factor in their payroll, for in many hospitals members of the nursing department make up nearly one-half the total number of employes in the hospital. Any significant rapid increase in the salaries of members of the nursing department is instantly reflected in a corresponding rise in costs to patients. In spite of their best intentions to pay employes more, hospital administrators do have a responsibility to their patients and to their governing boards to keep their over-all expenses within reasonable bounds.

2. Is it not time for the three-year diploma schools to form a countrywide organization of their own, headed by nurse educators who are in sympathy with the three-year hospital school program, who believe not only that three-year hospital schools will always be necessary but that they should continue to produce the great majority of nurses who are graduated each year? Such an organizational effort could only be started and carried to completion by nurses and nurse educators themselves. It would have, however, the enthusiastic backing of the great majority of hospital administrators.

3. The National League for Nursing has set up accreditation programs for hospital diploma schools and for collegiate schools of nursing. It is using all of its influence to promote those schools which seek and obtain accreditation, and to discourage from continuing in operation those schools which either do not seek accreditation or fail to obtain it.

To obtain accreditation from the National League for Nursing, a school must first of all go to considerable expense. The cost of visitation itself is not important. There is a tremendous mass of data that must be gathered to prepare for the accrediting visit. Finally, the standards for approval are so high that in these times of shortage of faculty members it is almost impossible for many schools to meet them. Even if they could obtain the necessary qualified personnel, the cost of the expanded program to the school would in many cases be prohibitive. Furthermore, the changes recommended in many cases do not produce better qualified nurses on graduation.

Yet, if a school does not seek and obtain accreditation, it soon finds that it suffers in many ways. In the first place, guidance counselors in high schools are being urged by nurse educators to direct their students only to those schools which are accredited. Unaccredited schools can look forward to increasing harassment and pressures from state licensing bodies, which are controlled in most cases by nurses who sympathize with the National League for Nursing program. Accredited schools will be favored in the awarding of state and federal scholarship grants. Nurses being prepared in universities for instruction and administration right now are being urged to seek employment only in accredited schools.

Most, if not all, of the states in this country have state accrediting agencies for schools of nursing, usually part of the education department in the state, operating through a board of nurse examiners or some similar body. The standards set by state licensing bodies are generally adequate in all respects for the protection of the lives and health of the citizens of that state. If there is any need for another accreditation program, it would better be carried out under the aegis of the Joint Commission on Accreditation of Hospitals, certainly insofar as hospital schools of nursing are concerned.

4. I believe that nurses and nursing organizations should support the movement for a national commission to make a long-range study of the nursing shortage. Such a commission should be able to get at the facts behind the nursing shortage, and in the long run all nurses should benefit thereby.

5. Finally, may I urge all nurses to speak up and make their voices heard in nursing and nursing education affairs. There are people in nursing who disagree with some of the points of view I have expressed here, but I suspect that actually they are in the minority. Yet they have succeeded in controlling the attitudes and policies of state and national organizations for many years. I am sure that there are hundreds, probably thousands, of nurses and nurse educators in the country who are not in complete sympathy with current trends in nursing, but who feel that it is useless to express their views or try to change the trends they dislike. If they can find strong leadership and able spokesmen, it is not too late to save the situation. I would hope to see this leadership developed from among nurses themselves. They are the ones who in the last analysis should control their own destinies.

Fire Safety Training Takes to the Road

For the first time, a state hospital association sponsors a series of fire safety institutes for hospital personnel and others in a tour of six state cities

CHARLES R. GAGE

ALL over Louisiana hospitals are training nursing personnel and others in fire fighting and emergency removal of patients as a direct result of a series of one-day institutes conducted in six key cities of the state on six consecutive days during National Hospital Week.

This was the first time in Louisiana, and possibly in the nation, that an effort was made to "bring the program to the people" through a week-long series of meetings designed to cover an entire state. The program was a huge success and reached more than three times as many persons as could have been transported to one institute in a central city.

One reason for the tremendous success of the week was the unusual enthusiasm of Lt. Robert McGrath, hospital inspector for the Fire Prevention Bureau of the Chicago Fire Department, who conducted the six institutes. Lt. McGrath not only taught but entertained the large crowds; his audiences were attentive and appreciative.

In each city, the institute was sponsored locally by the district hospital council and the area's fire departments.

The program consisted of demonstrations of how to control and extinguish fire, how to carry patients from danger areas properly, and how to coordinate fire fighting and removal of patients.

As is his custom, Lt. McGrath selected "students" from the audience at each session. After teaching them the essentials of handling fire, he taught them the various carries which are illustrated in his book, "Emergency Removal of Patients and First-Aid Fire Fighting in Hospitals."

As interesting and educational as the six institutes were, the major benefit of the week is only now beginning to be felt by hospitals all over the state as intensive training programs get under way in the various institutions. Although we had only six institutes, of one full day each, these are multiplying into training programs in scores of hospitals and the interest and enthusiasm are expected to spread to others as time goes on.

For example, the safety committee of Southern Baptist Hospital, New Orleans, is using two teams of students trained by Lt. McGrath to teach other

(*Continued on Page* 79)

Mr. Gage is executive secretary, Louisiana Hospital Association, New Orleans.

1. NEW ORLEANS: Right, four nurses practice blanket carry at the Veterans Administration hospital as other drill teams look on. Map of Louisiana shows six-city route Lt. McGrath traveled to conduct fire safety institutes during National Hospital Week.

ADMINISTRATORS, NURSES, FIREMEN AGREE ON PROGRAM VALUE

Dr. John C. Mackenzie, director, Touro Infirmary, New Orleans, and president, Louisiana Hospital Association.

"Preparedness for any disaster is mandatory in every hospital administrator's planning. Sessions of this type focus attention on this necessary training and should be held regularly for all key personnel. These people should in turn train others in their hospitals."

Raymond C. Wilson, administrator, Southern Baptist Hospital, New Orleans.

"The material and discussions presented were basic, logical and effective. I am sure that many of the ideas and procedures presented will be incorporated in the development of disaster plans of the hospitals."

Freeman May, administrator, Baptist Hospital, Alexandria, and president-elect, Louisiana Hospital Association.

"The lectures and demonstrations have given us sufficient know-how and the impetus to carry on a training program in each of our hospitals."

Myrtle A. Olstad, president, Louisiana State Nurses' Association, and chief nurse, Veterans Administration Hospital, Shreveport.

"It's wonderful that Lt. McGrath can select inexperienced persons from an audience and teach them to function efficiently as a team with so little training time."

Frank Domma, district chief, Baton Rouge Fire Department.

"Lt. McGrath knows his business and knows how to teach. He doesn't take anything for granted; even the firemen are learning from him."

2. BATON ROUGE: Right, hospital personnel at all levels must be trained to fight fire, evacuate patients. Here a student practical nurse learns how to put out gasoline fire with a CO_2 extinguisher.

3. LAKE CHARLES: Left, nurses learn how to place patients in air force rescue helicopter at Memorial Hospital. Nursing students from McNeese State College stand by to load second patient in the helicopter, as climax to demonstrations.

4. ALEXANDRIA: Right, hospital personnel attending fire safety institute see how a nurse can evacuate a patient even twice her own weight by sliding him along floor on a blanket. Institutes in each city were sponsored by the district hospital council and the area's fire department. Many firemen had high praise for the program.

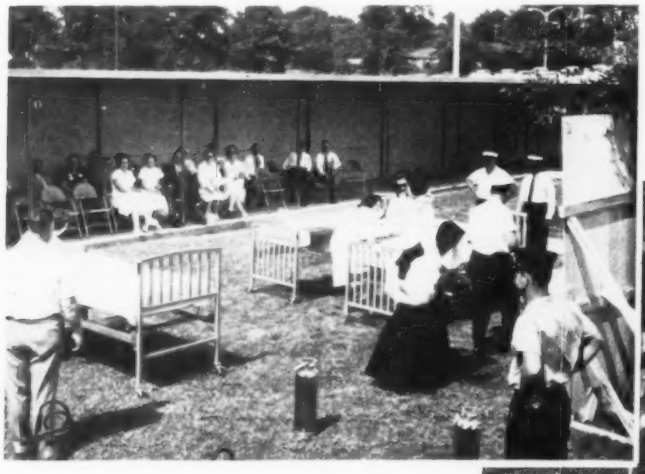
(*Continued From Page* 77)
students in the school, graduates and nurse's aides and other personnel in regularly scheduled sessions.

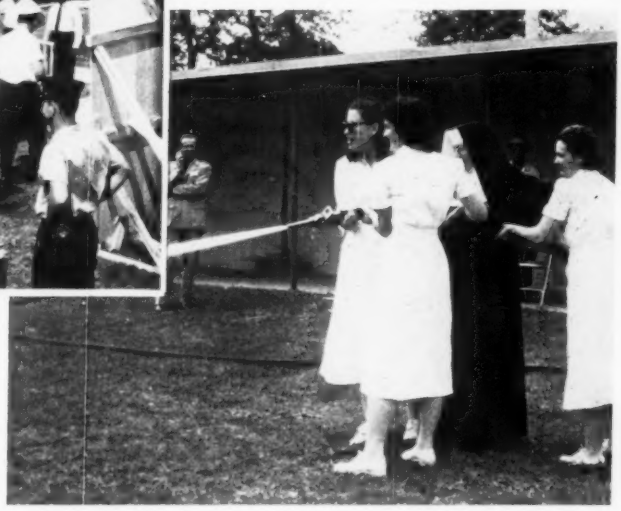
The school of nursing of Touro Infirmary, New Orleans, has incorporated this type of training as a permanent part of its curriculum.

Our Lady of the Lake Hospital in Baton Rouge had begun a teaching program using Lt. McGrath's book even before the institute. Now, with the aid of the fire department, it is going ahead with its training program with even more zeal, according to Doris Carnes, director of nursing service.

The fire safety institute was first contemplated last year as a two-day affair on the campus of Louisiana State University. When Lt. McGrath indicated he would be available for the two days, and for a week, if necessary, it was decided to put on the series of "one-day stands" around the state in an effort to reach the maximum number of persons. In order to provide personal attention to each registrant, it was decided to limit attendance in each city to 50 persons. Registration was $3 per person, including lunch.

First one, then another council announced that demand for registrations was beyond control and asked for permission to "accept a few more." Nearly six hundred persons participated during the six days, and twice that number could have been registered, if luncheon facilities and space limitations of the hospitals had permitted the association to lift restrictions on attendance. (*Cont. on Page* 80)





5. SHREVEPORT: Left, Sister tries out the hip carry removal; center, nurses start the swing carry, and a nurse at the far left extinguishes bed fire with a blanket. Below, three nurses and a Sister practice operation of hose line for the first time.

6. MONROE: Below, Sister Brigida, the supervisor of St. Reginald Hall, St. Francis Hospital, gets actual practice during the demonstration in putting out fire with a CO_2 extinguisher.

LOUISIANA HOSPITAL ASSOCIATION
CERTIFIES THAT

HAS SUCCESSFULLY PARTICIPATED
IN THE
Fire Emergency and Disaster Planning Institute

CITY:
DATE:

John C. Mackenzie, M.D.
PRESIDENT

Lt. Robert McGrath
INSTRUCTOR

Charles R. Gage
EXECUTIVE SECRETARY

Above, a copy of certificate awarded to the participants at institutes by the Louisiana Hospital Association.

Among the 580 persons who registered were representatives of 64 hospitals (out of 103 hospitals in the state association), two nursing homes, England Air Force Base, Lake Charles Air Force Base, the Ethyl Corporation, a school system, the state health department, a parish (county) health unit, and two state civil defense officials, three medical doctors, one mayor, and 71 firemen from 16 fire departments.

Judging by the interest shown, and the comments received from administrators and firemen participating, this extended statewide safety institute was one of the most progressive steps our association has ever taken.

Several persons have suggested that to encourage hospitals to organize fire safety programs with trained rescue teams the association should sponsor a series of elimination contests in the district councils prior to the state convention next spring and invite winners of the district drills to compete at the state meeting. The winning team at the state meeting would be recognized as the "fastest fire fighting and rescue team in the state." This would be a gimmick, of course, to encourage hospitals around the state to continue their intensified interest in fire safety which was sparked into action by the institutes. The drill would also provide the convention with excellent public relations possibilities.

An important factor in the success of the week-long series conducted during hospital week (which, incidentally, gave the hospitals valuable publicity at a most opportune time) was the unexcelled cooperation and support of the fire departments in the state. In every area, the chiefs, district chiefs, training officers, and rank and file firemen went all out to support the program.

Administrators, nursing service personnel, engineering and maintenance personnel, and members of the various fire departments are unanimous in their praise of the week's activities. All agree that hospitals in Louisiana now have the "steam" to carry on an adequate fire safety program.

If other states contemplate similar programs, we suggest that consideration be given to having two-day rather than one-day meetings. By having three institutes rather than six, approximately as many persons could be reached, and during the two days more detailed instruction could be given, with emphasis on such phases of fire safety as operating room explosions. One disadvantage of the six institutes on six consecutive days in six different cities was the physical hardship on the instructor (who survived without the slightest complaint) and the mad scramble to keep on schedule.

Early plans called for a talk on disaster planning at the noon hour in each city. Experience showed, however, that registrants needed the noon hour to relax, and most of the disaster planning talks were not given. In the near future, our council on hospital planning and plant operation under whose auspices these institutes were conducted in cooperation with the Southeastern Hospital Conference will sponsor a central school to discuss disaster planning.

Individual Hospital Plans Work Well, But Integration Fails in Midwest Tornado

SUSAN S. JENKINS

WHEN a green-black funnel of death roared out of the sky over Kansas City's populous south suburban area the evening of May 20, it caught hospitals at low ebb of manpower—the evening shift.

It found many doctors, nurses and technicians home at dinner, listening at first to radio and television warnings of hail and severe thunderstorms rapidly approaching from the southwest. Then within minutes the U. S. Weather Bureau picked up on radar the cloud mass with the sweeping tail and broadcast the dread word "Tornado!"

The doctors and hospital personnel who heard headed for their hospitals without waiting for calls. They came in quietly, with little comment, no show of excitement. They scrubbed and gowned, or went about appointed tasks to ready for what they knew was coming. And some plunged into work the instant they arrived, without benefit of gown or uniform.

There was no official alert to hospitals. The metropolitan area sprawls across a state line, reaches out into five counties, has 60 incorporated municipalities in addition to the four major ones of Kansas City, North Kansas City, Independence, Mo., and Kansas City, Kan. Getting this conglomeration of political subdivisions together in a coordinated disaster plan with a central control had proved too much. So there was no direct communication warning hospitals to prepare for casualties.

A patient listening to a bedside radio called a nurse's aide at St. Luke's Hospital. The aide told the head nurse, who relayed the news to the evening supervisor. Within 15 minutes, carts and wheel chairs were lined up at the ambulance entrance, identification tags were being readied, splints and orthopedic supplies were at the emergency department, instruments and packs were headed for sterilizers and autoclaves, drug supplies were being checked.

Not all hospitals got the warning so quickly. At the Menorah Medical Center, closest to the disaster, a switchboard operator called Leon Felson, acting administrator, who was at a meeting in the hospital.

"There are some cars jamming the ambulance entrance," she reported.

Mr. Felson went down to investigate, and met the first wave of incoming casualties.

Over the city, hospital disaster plans, whether written or unwritten, went into action with a speed that surpassed anybody's expectations.

There was no formal disaster plan on paper at Menorah, but intake of mass casualties had long been planned and discussed by administrator, medical staff, department heads. The plan was implemented on the spot and carried with few hitches through the next several hours of intense action.

St. Mary's Hospital, with a disaster plan tested in drills and hammered home in training programs, was a good example of readiness. Driveway to the floodlighted ambulance entrance was cleared, guards were stationed. Lined up at the dock was a waiting team of doctors, nurses and orderlies. Just inside was the triage area. An entire section of the first floor had been cleared by prearranged plan, and down the walls on both sides of the

(*Continued on Page* 145)

Miss Jenkins is executive director, Kansas City Area Hospital Association.

Perpetual Inventory Is Worth All It Costs

For the benefit of small hospital administrators who consider a perpetual inventory "too expensive," the author explains how his system of control works and how much money it saved the hospital

LEON A. BONDI

IN THE winter of 1954-55 I set out to discover to what extent small hospitals were making use of perpetual inventory control.

Believing the best approach to this project was to compare the small hospitals of two states, instead of gathering information from hospitals all over the country, I chose Pennsylvania and Illinois for my study, since the number of hospitals of 150 beds or less in these two states corresponded more closely than those of any other two.

There were 134 hospitals listed in this category for Illinois, while Pennsylvania had 113. Of 247 questionnaires mailed to these hospitals, 119, or 48 per cent, were returned.

Much interesting information was obtained from the replies, but none was more thought-provoking than the answers to the last question which asked hospitals that did *not* have a perpetual inventory to explain why and also to describe their systems of purchasing and stores handling.

Fifty-three hospitals, or 45 per cent of those answering the questionnaire, said their hospitals did not have perpetual inventory control. Of these, six explained that it "would require too much personnel"; three stated that "the board of trustees is against such a system," and 12 said in substance that "it would be too expensive to establish." Where does a hospital become penny-wise and dollar-foolish?

Mr. Bondi is administrator of St. Luke's Hospital, Davenport, Iowa.

The data used by the author were collected for his fellowship thesis in the American College of Hospital Administrators.

After going over these statements, I wondered just what a hospital gets out of a system in comparison to the amount of money and energy put into it. St. Luke's Hospital, Davenport, Iowa, has 185 beds and 30 bassinets. The system here entails four visible card files and two full-time employes to operate it. With the exception of a few hours a month spent in duplicating material, these two employes spend their 40 hour week entering new items on the inventory cards and taking off items and supplies issued. They also help with purchasing.

BOARD REQUIRES INVENTORY

The board of trustees of the hospital would not agree to a storeroom without inventory control of some type. The board is made up of successful business and professional men who use a system of control in their own businesses. The auditing firm the board employs has said it would not certify reports of the institution unless there was some sort of control.

Each of the inventory employes has a certain area of responsibility. One area consists of all the drugs, food, oxygen and anesthetic gas; the other covers the rest of the inventory. They can provide information about the stock and how long it has been stocked. They can tell if items are not being used or how rapid is the turnover of other items. In a few seconds they can tell how many sheets were issued last year, the year before last, and the year before that. They often call attention to the ordering habits of head nurses and ask if it is possible for a 37 bed nursing unit to use so many flashlight batteries or light bulbs in a week's time, or question the use of some other item that seems out of balance. They ask such questions as, "Why have we stopped getting requisitions for this item?"

What good have we derived from use of this system?

It has been found that the use and purchasing of supplies is sufficient to pay for the working of the perpetual control system in this hospital and for the salaries of those who issue and operate the control system. Here are a few specific examples.

Recently the store clerk who handles the issuing of and inventory control on rubber gloves advised the purchasing department that a certain type of nonallergic rubber glove was no longer being requested by the operating room. A check showed that the surgeons who used nonallergic gloves had found a kind they liked better and that these also were being purchased. The stock of the old gloves consisted of 32 dozen pairs, all new enough to be returned for credit. The manufacturer agreed to take them back and issue credit. This saving would have been difficult to achieve under a system where no inventory records were kept.

Perhaps the largest saving for the hospital results from our ability to take advantage of quantity purchasing. We know what amount of any item is used in a month, quarter, year or other unit of time. This makes it possible to

schedule shipments in cotton and gauze dressing items, and to get the larger case prices, while not having funds tied up in storage of the items. In other words, it is known which items and how much of each are used in 90 days.

Next largest saving results from pool buying to cover a period where the consumption is known, such as buying an assortment of thermometers, hypodermic syringes and needles to make up an order when a special price can be obtained if so many dollars' worth of one company's product is purchased at one time. A recent order totaling $796.32 of these items, which our records showed to be about a six months' supply of the larger items, saved us $58.80, or 7.39 per cent. Thus, in a year our savings would be nearly 15 per cent on this one class of goods with a net saving of 9 per cent, with an allowance of 6 per cent for the use of funds tied up in inventory on the shelves.

SIMPLIFIES CONTRACT BUYING

The whole matter of contract buying is simplified by the use of perpetual inventory control. Thus we have a saving in time as well as in hard cash. It is possible, with a good perpetual inventory system, to have a continuous shipping schedule set up on certain items and thus receive the advantage of maximum quantity prices with minimum amounts of cash tied up. This method can be used for such items as obstetrical pads, surgical sponges, and cotton balls.

Sometimes pharmaceutical manufacturers make special offers that allow sizable savings. Past performance, indicated on card records, will tell in a few seconds how rapidly we can dispose of the items.

One drug item that is used in annual quantities of more than 15,000 saves $35, or 5 per cent, on a 5000 purchase at an outlay of less than $700. This leaves a net saving of 3 per cent, allowing interest at the rate of 6 per cent for the funds tied up on a third of a year's purchase.

Similar savings can be made on canned foods by contract purchasing and quantity buying at the time specials are available and when new packs come on the market.

Savings achieved by knowing the quantities used in a given period are not applicable to foods, drugs and hospital supplies alone. Overhead items can be purchased at large discounts if the turnover and usage are known. This is true particularly with printing and stationery items. Recently we were informed that we could save 23 per cent on one item if we could purchase 20,000 instead of the 10,000 we had been in the habit of purchasing. Naturally, it was possible to take advantage of this saving, even though it would take approximately 30 months to use 20,000 payroll checks. Thus, the second 10,000 cost 54 per cent of the first 10,000. Similar savings were available in the purchasing of admission forms, billing statements, ledger cards, and so on.

HOW CLERKS SPEND TIME

If we attempted to divide the time of the two inventory employes into three categories — inventory control keeping, stores issuing and receiving of new merchandise, and mimeograph production—it would be on roughly 60 per cent inventory control, 30 per cent stores issuing and receiving, and 10 per cent for mimeograph work.

The 60 per cent of time these clerks put in on the system would be almost paid for out of the savings the hospital could make by using the inventory system as a purchasing control and guide only. It would be safe to assume that half of the time spent with the system would be paid for out of purchasing savings. Therefore, it can be assumed that the cost of control is 30 per cent of the combined salaries of the clerks. This is not too much to spend for such a management tool as stock control and protection against illegal usage of hospital supplies by misappropriation and application. Then, too, the accounting system is a better management tool, since monthly operating statements give a truer picture of the cost of operation and an accurate figure to the current asset account on the balance sheet, reflecting the value of supplies on the shelves.

Answers to the questionnaire show that hospitals with inventory control carry from $21.53 to $42.71 in inventory per bed and that those without inventory control show a range of from $21.91 to $38.33 per bed. This would indicate that inventory is an important item in hospital operation. In both groups, the higher figures were in the Illinois hospitals. The larger figures for those hospitals with control systems could be accounted for by the theory that hospitals using controls on a perpetual basis tend to buy in larger quantities, since their purchasing can be based on experience over a period of years, made possible by good record ledger cards. In this hospital, a year's supply of sheets is purchased when prices are known to be best. There are times when the market changes direction over a wide range because of some abnormal fluctuation in the textile field, but the hospital has yet to be on the wrong side of the market. Perhaps this has been luck. Members of the hospital purchasing department would prefer to think that their records have helped more than luck.

If a hospital of 150 beds in Illinois had an inventory of $40.71 per bed, the average of the three group figures submitted in answer to the questionnaires, it would have $6,106.50 tied up in merchandise on the shelves. This seems low to me and probably the respondent did not return all the information I had sought. St. Luke's Hospital shows an inventory of about $59,000, or $318.09 per bed, which includes food, drugs, intravenous solutions, linens, general hospital items, and routine printed forms and printed items. Is it not logical, then, to assume that some of the operating funds of a hospital should be used to supervise, conserve and control such a large investment? Is it asking too much to spend one-half of 1 per cent of a million dollar budget for the control, receiving and issuing of supplies, and mimeograph production? At our hospital we think not. In fact, the more we think of it, the more impressed we are with the whole system and its worth to the hospital.

SET COURSE FOR CONTROL

Looking back over the answers to my question: "Why have you not gone to the inventory control and perpetual inventory system?" I wonder how much thought was given to the answering of the question by those who returned their questionnaires. I hope that these few results, recorded here, will help them to change their thoughts and set a new course for their hospitals along the charted path of a well controlled perpetual inventory system.

It is easy to put off a time consuming project, such as the installation of an inventory control system, by saying it will cost too much or need too many people. Once you have installed such a system in your hospital and can see the results it produces, you'll laugh at your former statements about perpetual inventory control. I know some administrators who have.

ABOUT PEOPLE

Administrators


Seymour Schulman

Seymour Schulman has been appointed administrative director of Cedars of Lebanon Hospital, Los Angeles. He goes to Cedars of Lebanon from City of Hope Medical Center, Duarte, Calif., where he was administrator for three years and assistant administrator for one year prior to that. Recently elected treasurer of the Hospital Council of Southern California, Mr. Schulman served his administrative residency at Cedars of Lebanon and received his degree in hospital administration from the University of California.

William A. Markey, assistant administrator of City of Hope Medical Center, Duarte, Calif., has been named administrator. He succeeds **Seymour Schulman.** Mr. Markey went to City of Hope from Montefiore Hospital, Pittsburgh, where he held the posts of assistant director and director of the outpatient department. His background also includes service as administrative resident at Beth Israel Hospital, Boston, and administrative experience in the psychiatric clinic of the U.S. Army Hospital at Fort Belvoir, Va. He is a graduate of the hospital administration course of Yale University and a member of the American Hospital Association and American Public Health Association.

Harold L. Autrey has been appointed administrative assistant of University Hospitals, Cleveland, succeeding **Ernest C. Gray Jr.,** who has been named director of Lake Forest Hospital, Lake Forest, Ill. Mr. Gray, who has been


Harold L. Autrey


Ernest C. Gray Jr.

assistant to the director at Hanna Pavilion, joined the University Hospitals' administrative staff in 1954. Mr. Autrey, who has been an administrative resident at the hospital during the last year, is a graduate of the University of Chicago's course in hospital administration.


Eugene J. O'Meara

Eugene J. O'Meara, assistant superintendent of Altoona Hospital, Altoona, Pa., has been named administrator of Sharon General Hospital, Sharon, Pa. He succeeds **C. R. Youngquist,** whose appointment as administrator of Shadyside Hospital, Pittsburgh, was announced in the April issue of The Modern Hospital. Mr. O'Meara, a graduate of the course in hospital administration at the University of Chicago, is a lecturer in personnel administration in the school of public health at the University of Pittsburgh.

Jack W. Rivall has assumed the position of superintendent of Doctors Memorial Hospital, Minneapolis. He formerly served at St. Luke's Hospital, Duluth, Minn., as assistant superintendent, administrative assistant, and administrative resident. Mr. Rivall, a graduate of the hospital administration program of the University of Minnesota, is president of the Minnesota Hospital Association's second district.


Robert W. Lyons

Robert W. Lyons has been named assistant administrative director of Cedars of Lebanon Hospital, Los Angeles. Mr. Lyons formerly served as administrator of Atchison Hospital, Atchison, Kan., and as assistant administrator of St. Luke's Hospital, Kansas City, Mo. A member of the American College of Hospital Administrators, he holds a master's degree in hospital administration from Northwestern University.

Roger B. Labouteley, assistant administrator of Cooley Dickinson Hospital, Northampton, Mass., has accepted the position of administrator of Anna Jacques Hospital, Newburyport, Mass. Mr. Labouteley has served as administrative resident and as assistant administrator at Cooley Dickinson Hospital since 1954. He is a graduate of the course in hospital administration at Northwestern University.


Howard M. Winholtz

Howard M. Winholtz has been named assistant administrator of Rochester Methodist Hospital, Rochester, Minn. Mr. Winholtz has been manager of Worthington Clinic, Worthington, Minn., for the last six years and prior to that was associate professor of business administration at Augsburg College, Minneapolis. He is a graduate of the University of Omaha and holds master's degrees in business administration and in hospital administration from the University of Minnesota.


Albert R. Sargent

Albert R. Sargent has been named assistant director of Children's Hospital, Buffalo, N.Y. Mr. Sargent previously held administrative posts at Meadowbrook Hospital, Hempstead, N.Y., and Nassau Hospital, Mineola, N.Y. He served his residency in hospital administration at Herrick Memorial Hospital, Berkeley, Calif., and is a graduate of Columbia University School of Public Health and Administrative Medicine.

Gary Bricker has been appointed administrator of Community Hospital, Falls City, Neb., succeeding **Robert W. Cooper,** whose resignation was announced in the April issue of The Modern Hospital. Mr. Bricker, who was administrator of Community Hospital at Hiawatha, Kan., for two years, will be succeeded there by **Donald E. Wise.** Mr. Wise, a technician at the Kansas hospital, will continue to supervise laboratory and x-ray work.

Wilbur L. Mauzy, administrator at Memorial Hospital of Floyd County, New Albany, Ind., for five years, has been named administrator of Howard County Hospital, now under construction near Kokomo, Ind. Mr. Mauzy, who will begin his new duties August 1, is a member of the American College of Hospital Administrators.

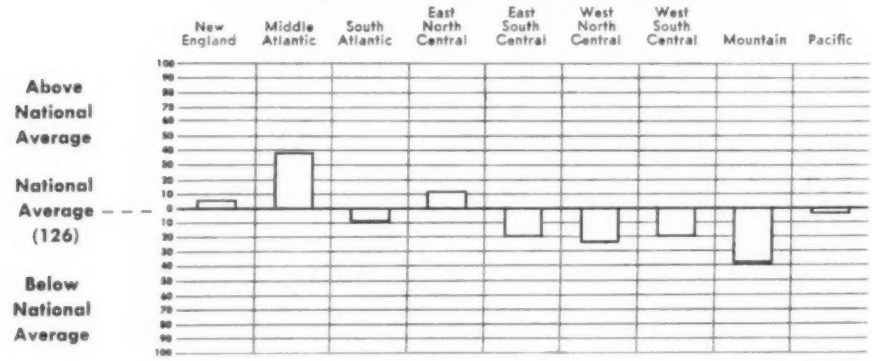
(*Continued on Page* 160)

Regional Variations in Hospital Statistics

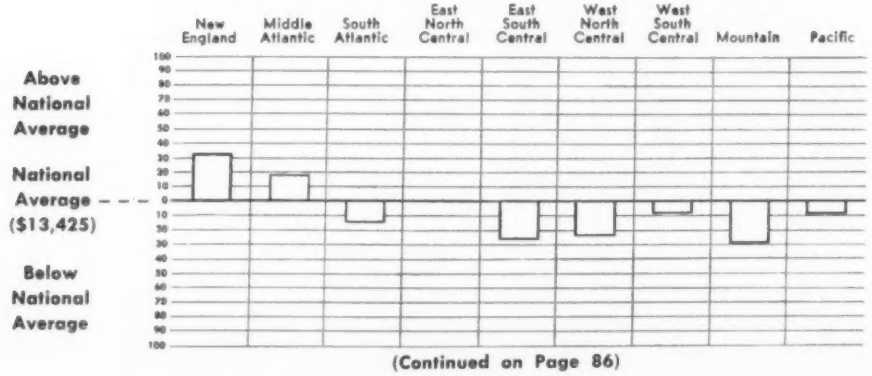
This study shows regional variations among nonprofit short-term general and special hospitals as to size of hospital, total assets per bed, plant assets per bed, expenses per patient day, payroll per patient day, and the number of full-time personnel employed per 100 patients

LOUIS BLOCK, Dr. P.H.
Chief, Research Grants Branch
Division of Hospital and Medical Facilities
Public Health Service, Washington, D.C.

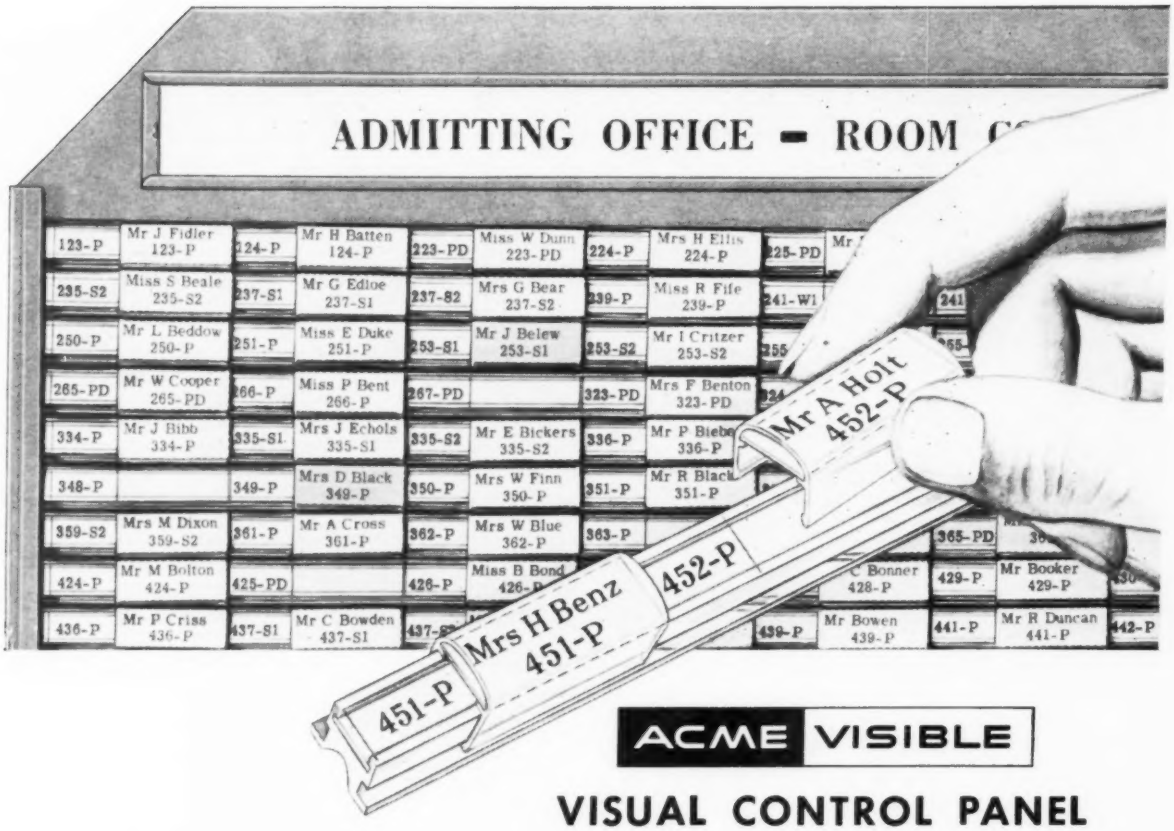
SIZE OF HOSPITAL (Nonprofit Short-Term Hospitals)
Per Cent Regional Variation From National Average (126 Beds)



TOTAL ASSETS PER BED (Nonprofit Short-Term Hospitals)
Per Cent Regional Variation From National Average ($13,425)



(Continued on Page 86)



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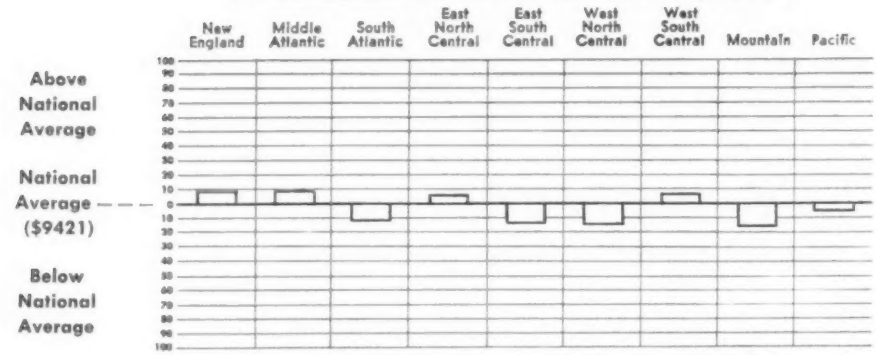
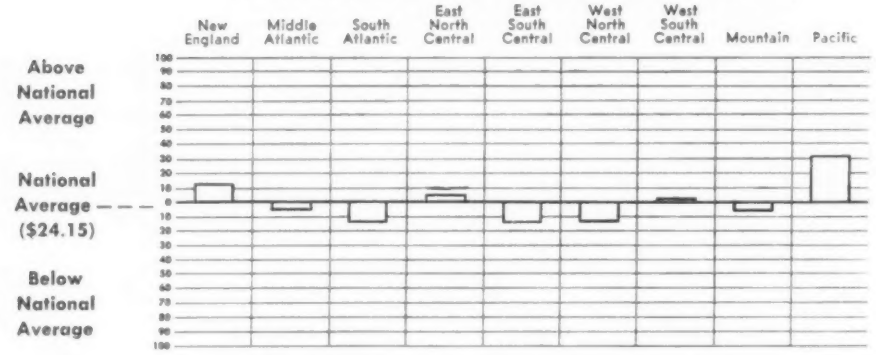
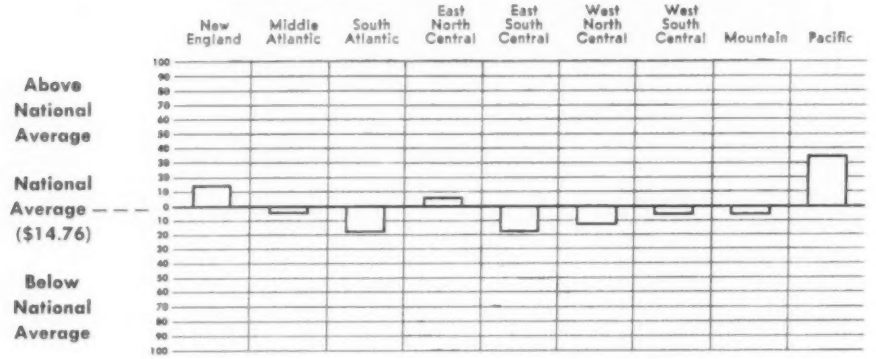
PLANT ASSETS PER BED (Nonprofit Short-Term Hospitals)
Per Cent Regional Variation From National Average ($9421)



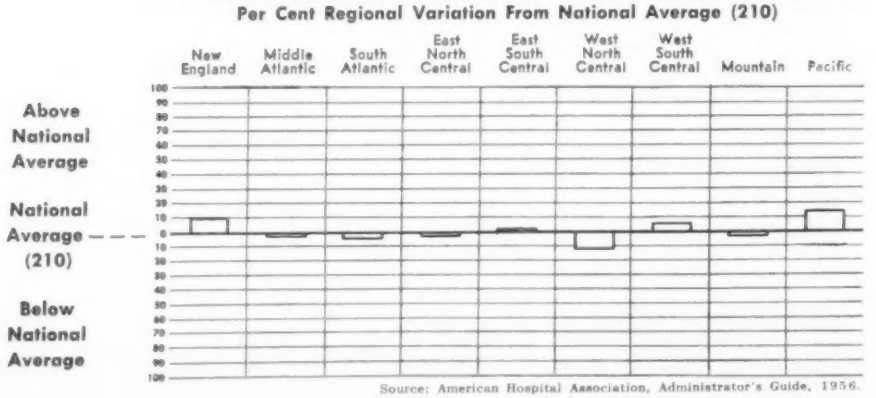
EXPENSES PER PATIENT DAY (Nonprofit Short-Term Hospitals)
Per Cent Regional Variation From National Average ($24.15)



PAYROLL PER PATIENT DAY (Nonprofit Short-Term Hospitals)
Per Cent Regional Variation From National Average ($14.76)



FULL-TIME PERSONNEL PER 100 PATIENTS (Nonprofit Short-Term Hospitals)
Per Cent Regional Variation From National Average (210)



Source: American Hospital Association, Administrator's Guide, 1956.

What Patients Expect From Their Doctors

In this study, fifty patients at one city clinic tell what they think about the way their medical care is handled and what traits they believe a good doctor should have

GEORGE G. READER, M.D., LOIS PRATT, and MARGARET C. MUDD

IT HAS long been assumed that good patient care is provided in good hospitals; that is, if a hospital is well managed and staffed by competent physicians, nurses and other personnel, its patients must be receiving optimal care. But this happy notion avoids the question of what precisely constitutes good care for patients, for the criteria for judging adequacy of care have not yet been fully developed nor have the significant variables been examined fully.

At the New York Hospital-Cornell Medical Center, the staff of the Comprehensive Care and Teaching Program* found it necessary to consider seriously how the patient is best served in order to spell this out for medical students. Accordingly, a group of investigators, which has included physicians, nurses, social workers, sociologists and statisticians, began studies five years ago which have tentatively explored a number of aspects of the care of ambulatory patients. The "laboratory" site of the General Medical Clinic of the Center was chosen because of its convenience as the major base of operations of the Comprehensive Care and Teaching Program.

Dr. Reader is director of the Comprehensive Care and Teaching Program at New York Hospital-Cornell Medical Center; Miss Pratt is assistant professor in the department of business administration, Fairleigh Dickinson University, Teaneck, N.J., and Miss Mudd is a research writer for the Sloan-Kettering Institute for Cancer Research. Their survey was originally presented as a paper before the American Public Health Association, 1956.

*A program designed to teach fourth year students application of medical knowledge in a practice situation, to improve care of ambulatory patients, and to carry out research in medical education and patient care. See Reader, G. G.: Comprehensive Medical Care, J. Med. Ed., July 1953.

STUDIES DEFINED POPULATION

The early studies were directed to defining the locale and population in such terms as number of patient visits per unit time, age, sex, economic level and cultural origins of patients, and diagnostic categories. Attempts also have been made to determine costs of services as a preliminary to determining how care may be made more complete without inordinately increasing expense. The philosophy of the program from the outset was to have all necessary services available but to use discrimination in their application, following the principle that services provided should always accord with the needs of individual patients.

These studies led to investigations into adequacy of patient care, first by review of charts for diagnostic accuracy and appropriateness of therapy. Later, when it was discovered that quality of care was at a consistently high level by those criteria, interest turned to patients' satisfaction with their care. Ultimately, the question to be answered is whether patients are restored to their optimal level of health by the care they receive, and for this, research must yet be done to set baselines from which improvement may be measured and to define criteria of optimal improvement.

The study shows that patients have somewhat different attitudes and expectations from those that might have been surmised, and it points the way to further research not only into patients' opinions but into the doctor-patient relationship as well. Extension of this kind of research into ward, private pavilion, and physicians' offices will no doubt eventually be necessary, not only to determine the effects of different locales but also to study the attitudes and values of patients from varying socio-economic backgrounds.

Findings are based on an intensive study of 50 patient-physician relationships. The sample was randomly selected from patients accepted by the admitting office for clinic care.

Patients were interviewed when they first came to the admitting office to make a future appointment for initial diagnostic examination about their conception and knowledge of their medical problem, their ultimate medical care goals, what they expected the doctor to do, their conception of the good physician, their evaluation of clinic care and private physicians, and their previous medical care experience. The patients were subsequently interviewed after each visit with the physician on these same top-

(*Continued on Page* 90)

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ics, and on their assessment of what had happened so far and what had happened on a given visit. This interviewing was done by a trained investigator, a young woman in street dress, who identified herself as representing the hospital in a study of what patients think of medical care, but as having no connection with the clinic physicians.

In addition, all interaction between patient and physician was observed and recorded at each visit by a second social scientist who wore a white coat and was identified to the patient as a doctor interested in the patient's problem. She took no part in the interaction but merely sat quietly in the corner making notes.

RECORDED NUMBER OF VISITS

These patients were followed for as long as they continued to see a clinic physician. This ranged up to 34 visits over an 18 month period. The average number of visits by a patient was four or five. Just under two-thirds of the patients were women and about one-third men. They ranged in age from 15 to 72, the average being 45. The medical problems represented a wide range of clinical entities. Results are summarized in the following paragraphs:

1. Attitudes toward clinic care. Sixty-two per cent of the clinic patients reported that, if they had their choice, they would prefer to obtain care from a clinic rather than from a private physician. It should be noted that this is the opinion of a group whose principal medical experience may be with clinics, whose experience with private physicians may have been with below average doctors, and who have made up their minds to seek care from our clinic.

Fourteen per cent said they would prefer a private physician. That is, those who do not state a preference for clinics more frequently say they "don't know" which they prefer, than prefer private physicians.

Evidence for the clinic patients' preference for clinic care is found in the fact that 66 per cent of the patients think clinic doctors are more capable than private doctors.

However, it does not appear that patients think clinic doctors take a greater interest in patients than do private doctors. While many more patients thought clinic physicians surpassed private physicians in the interest shown in the patient, than the reverse, only a third of the patients made the statement that clinic doctors were superior in this regard—a large number (44 per cent) did not know who was better.

With respect to patients' evaluation of the particular clinic studied, one-half the patients felt they would obtain better medical care at this clinic than from a private doctor. Four per cent thought a private doctor would give better care; the remainder thought there would be no difference or did not know which would be better.

2. Patients' definitions of their problems. Before the patients had been seen by the physician in the clinic, only a small number (14 per cent of the sample) had a firm conviction of what their diagnosis or disease was. All of these had been diagnosed by a previous physician, and had accepted his conclusion. A majority of patients (two-thirds of the sample) tentatively defined their problem as a serious disease. That is, while hoping this was not the case, they strongly feared they might have a serious illness. Among this group, more than three-fifths (or two-fifths of all patients) suspected some specific disease, and these were restricted almost entirely to tuberculosis, cancer and heart disease (about equally divided). The remaining patients (18 per cent of the sample) were extremely vague about what their diagnosis might be, some feeling the probability was high that they did not have a disease, but wanting to make sure; others apparently unconcerned about what the diagnosis might be, but wanting treatment for symptoms.

At the end of the study period, after the patients had interacted with the physician for a period of weeks or months, two-thirds had a fairly firm and accurate notion of their diagnosis. This is not to say that they had full comprehension of their problem—that will be discussed later—but only that they could accurately report the diagnosis the physician had made. One-third of the patients, on the other hand, did not end up with a clear notion of what their problem was. It was further found that, of patients diagnosed as having an organic disease, almost all came to know the diagnosis; while those diagnosed as having no significant medical problem were slightly less likely to know the diagnosis, and those diagnosed as having symptoms of emotional origin were least likely to know the diagnosis.

While two-thirds of the patients could accurately state what their diagnosis was, fewer patients could be said to have any depth of understanding about the etiology of their condition or about the manifestations of the disease. One-half of all patients in the sample were classified as having almost no accurate comprehension of their condition beyond the name for it, and some of these did not even know the name; one-fourth of all patients were classed as having "some" information, and the remaining one-fourth were classed as having "thorough" understanding. The "thorough" classification was rather liberal, and a patient was so classified if he could make even a brief and partial, but coherent, statement about the disease.

3. Patients' general medical care goals. The dominant goal initially of two-thirds of the patients was to find out if they had a serious disease. The other one-third of the sample either wanted a general checkup and a diagnosis, apparently not anticipating a serious problem; or already believed they knew the diagnosis and wanted treatment, or wanted treatment for their problem without being concerned about the diagnosis.

WANT RELIEF OF SYMPTOMS

Almost three-fourths of all the patients indicated initially that they wanted some kind of treatment or relief of their symptoms, with almost two-thirds of these (or slightly under half of all the patients) specifying the kind of medication or the particular result they wanted to achieve (for example, to be able to sleep).

It has already been indicated that two-thirds of the patients had as their chief goal in seeking medical care obtaining a conclusive answer to their basic question—"Am I seriously ill and what do I have?" On this broad level many patients were concerned to obtain information from physicians.

Aside from this interest in learning about the seriousness of their condition and a name for it, it is also important to know whether patients want to obtain more detailed understanding of their condition—the etiology, what the symptoms mean, the purpose of procedures and treatment, and information at each step as to what is happening. The evidence is somewhat ambiguous but points to the following conclusion: that, while there is no insistent demand for information among the patients, there is apparently a cer-

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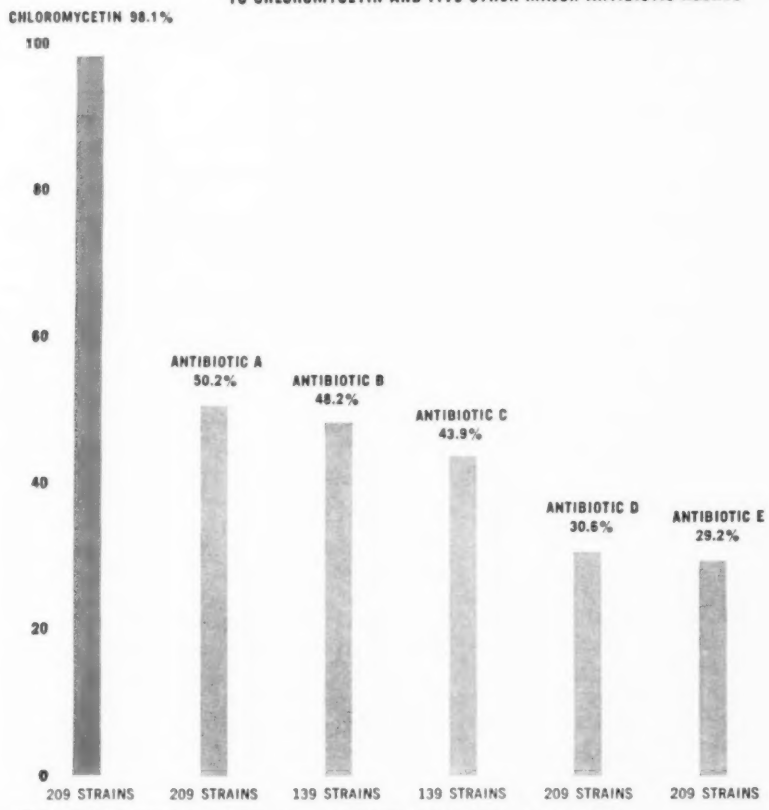

*This graph is adapted from Spink, W. W.: *Ann. New York Acad. Sc.* 65:175, 1956.

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tain amount of latent interest in obtaining information. The evidence is as follows:

Patients seldom made forceful demands for information to the physician. One-third made no request for information at any time, and the average number of requests for information was 1.4 questions per visit. Furthermore, the questions patients asked more frequently pertained to the practical arrangements of medical care (where to go, how to execute a particular instruction, and so on) than to the more basic issues.

It is not possible to conclude from this one finding that the patients felt no need for basic and detailed information, for they may have felt it inappropriate to demand this of a physician.

TRAITS OF GOOD PHYSICIAN

When patients were asked further, by means of an open-ended question, to characterize a good physician, only five mentioned that the type or extent of information the physician gave was relevant. These five patients all indicated that it was important for a physician to be truthful, but two of the five were more concerned that the truth be well tempered by kindness or hopefulness. This is contrary to what has been found in a different medical setting. When patients in a Veterans Administration tuberculosis sanatorium were asked what the most important quality was for a physician to have, 57 per cent said "to keep the patient informed." In that setting, where the patient's life is more circumscribed by the hospital, he is more dependent on communication from the physician than seems to be true for ambulatory patients.

In addition, the patient was asked to evaluate his own physician's actual performance in this regard, specifically, as to whether the doctor explained things to the patient fully, clearly and in nontechnical language, whether he gave the patient a chance to talk, and whether he answered questions. There was scant indication from answers to these questions that patients felt particularly critical of their physicians for giving them too little information. Yet we saw that the physicians had not, by and large, given elaborate explanations of basic disease issues.

One final type of evidence suggests, however, that there may be a latent interest in obtaining information. When the instances are summed up in which the patient directly or indirectly indicated a desire for information to the interviewer as well as to the physician, it is found that a substantial proportion of the patients had at some time shown an interest in some fundamental aspects of their condition. For example, patients were found to say: "I wish he'd told me about such-and-such"; or "I wonder what that means."

Type of Information	Per Cent Patients Showing Interest
Test results and their implications	44
The etiology of disease, what it consists of, organs involved	68
Seriousness of illness	54
Other information about the condition	72

4. Patients' expectations of clinic visit. Before their first visit to the clinic, patients were asked: "Now, you may not have a clear idea of what will happen on your visit in the clinic, but what do you *guess* will happen? Someone will call your name, and then what?"

This was asked in order to determine what patients expected to happen, how concise their expectations were, and possible discrepancy between their expectations and the current pattern of administering care in the clinic. The practice is to give the patient a complete workup on his first visit, including history, physical examination and urinalysis; to order the necessary tests to be made before the next visit, and to refer the patient to the nurse for explanation of tests or special teaching. A social worker and special consultants may also see the patient on the first visit if circumstances direct.

Practically all patients expected to be questioned by the physician on the first visit about their present illness, and 56 per cent thought he would ask about past illnesses. But a large majority said they did not know whether they would be questioned about all systems of the body, the family medical history, personal history or psychological problems. Furthermore, 36 per cent said they did not know whether they would be examined; 42 per cent expected some tests to be ordered, while 50 per cent did not know.

There was a wide divergence of opinion about how long the first visit would last, ranging from 15 minutes to five hours. However, 60 per cent did not venture even a guess as to how long it would take. Similarly, 70 per cent could not estimate how many visits or how many weeks or months would be required.

Before they had been seen by the physician, patients were asked: "How much do you think can be done for you here?" Patients' responses to this question were found to include two dimensions—how completely they expected to be returned to good health, and their degree of confidence that this would be accomplished. With respect to how much they expected would be accomplished, 64 per cent anticipated positive developments. Only one patient expected that little would be accomplished. The remainder did not know what to expect. Closer examination of the responses discloses, however, that only 28 per cent of the patients anticipated a complete cure or that they would be returned to good health, and a third of these merely hoped, rather than confidently expected, to be completely cured.

DEGREE OF CONFIDENCE

When the other dimension is considered, that is, the degree of confidence the patients felt that something positive would be accomplished, it is found that 60 per cent of the patients did not know or were hopeful, but uncertain, of positive accomplishments; 32 per cent were rather certain or confident of positive accomplishments. It may be that these figures actually overstate the confidence of the group, for some patients may have stated in positive terms what they merely hoped would happen.

5. Patients' concepts of a good doctor. Patients were asked this question: "Now I'd like to get an idea of what you prefer a doctor to be like and what you prefer a doctor not to be like? To help you think about this, take a doctor you've gone to whom you've liked quite well. (Have you thought of one?) What made you like him?"

Responses Given	Per Cent
Kindness, understanding, interest, sympathy, encouragement	50
Intelligence, knowledge, skill, training	42
Results he obtains, progress	26
Honesty, sincerity, tells the truth, explains things when I ask	18
Inspires confidence	10
Takes his time, is not in a hurry	4
Tells me just what to do	2

It can be seen from this list of attributes that a large segment of the group mentioned factors related to the physician's medical competence, and another large group mentioned factors concerned with how the physician relates to the patient or deals with the

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patient. If the responses are divided into these two broader types of answers, it is found that 60 per cent mentioned technical competence as a requisite of a good physician, and 58 per cent mentioned interpersonal relations with the patient. With further investigation it will be possible to ascertain whether this attitude difference is a basic distinguishing factor among patients—a factor which makes a great difference in their expectations of medical care, their satisfaction with care received, and their ability to make effective use of a physician's help. It will also be important to determine whether the patients' views of the good physician are more a reflection of a patient's personality, an outgrowth of the particular medical problem, or some other factor.

Patients were also asked: "Now think of a doctor that you did not like as well, or you can think of any things about this first doctor that you didn't particularly like. What sorts of things didn't you like?"

Patients reported the lack of, or the negative form of, the same type of attributes that were indicated under the "good physician." Fifty per cent mentioned lack of medical competence and 44 per cent mentioned poor interpersonal relations.

Responses Given	Per Cent
No results (poor results); if I didn't get better	30
Unfriendly, makes you feel you're unimportant to him, not interested in you, heartless, does not encourage	28
Unskilled, unintelligent, doesn't know his stuff, poor training	20
Dishonest, insincere, does not tell the truth or discuss problem	12
Rushes, too busy, takes your money and you can go	10
Does not inspire confidence	2

A majority of the patients were favorably disposed to clinic care and sought it in preference to seeing a private physician. This may be related to the fact that two-thirds of the patients defined their problem as a serious disease and for that reason sought security in the prestige of a medical center clinic. It also suggests that fear is a major motivation of many medical clinic patients.

That one-third of the patients did not end up with a clear idea of their problem points out the great difficulties of communication in the doctor-patient relationship. It might be supposed that a mechanism such as denial was at work here in relation to an illness that threatened the life of the patient and that he could not accept. This may be so, but the data show that it is the group with functional illnesses that fails to learn diagnoses, an example possibly of the reluctance of physicians to give patients labels that are socially taboo, such as "psychoneurotic," and the reluctance of patients to accept such designations.

With almost three-fourths of all the patients wanting treatment and most of these able to specify the kind of medication or particular result they wanted, the pressure that physicians are under to render symptomatic treatment becomes clear. Patients seeking medical care from private physicians might be expected to emphasize these desires even more strongly than those approaching the intimidating medical bureaucracy of the medical center; under a fee for service system of solo practice, patients might well be better able to enforce their desires for symptomatic treatment, too.

PATIENTS NEEDED EXPLANATIONS

The discovery that patients seemed to have a need for explanations of their condition by the physicians who cared for them and yet made no particular effort to obtain this information by direct questioning, just as they failed to criticize physicians for neglecting to give clear explanations, suggests that patients do not expect doctors to attempt to fulfill this need. Such an attitude may reflect the passive outlook of the clinic group and may be in marked contrast to patients of a higher socio-economic level. Further research studies will be necessary to test this hypothesis.

Passivity on the part of the clinic patient is further suggested by his response to queries about what he expects will be done for him. Most of the patients were willing to leave this entirely in the hands of the doctor even to the degree that they were unwilling to speculate about it although they often had in mind some specific form of treatment to alleviate symptoms.

Since patients almost invariably spoke in terms of a single physician rather than the clinic at large, it is evident that they consider the role of the outpatient department in terms of the individual physicians with whom they deal, and it confirms the idea that the clinic organization should ideally provide a setting for the optimal development of an enduring doctor-patient relationship.

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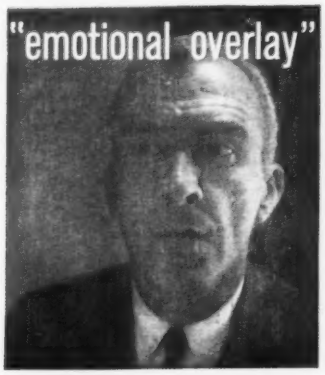

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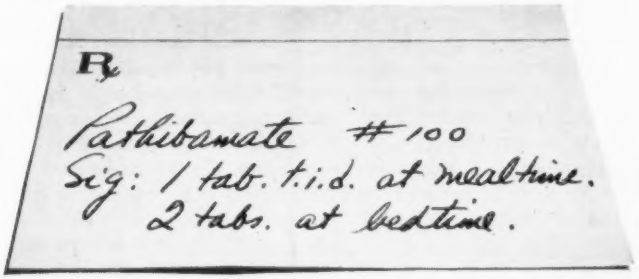

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A Review of the New Antibiotics

Penicillin V, Novobiocin, Cycloserine, Oleandomycin and Vancomycin

AN IDEAL antibiotic is one which (a) is effective against all pathogenic bacteria in low concentrations when administered systemically; (b) does not permit the development of resistance in organisms exposed to it in therapeutic concentrations; (c) produces no adverse effects upon the host, and (d) is relatively inexpensive to the patient.

Inasmuch as no antibiotic in current use approaches this ideal, new, more effective and less dangerous antibacterial agents are constantly being sought. As a result of this effort, several advances have been made in the field of antibiotic chemotherapy. Older antibiotic agents have been modified chemically to advantage; new and effective antibiotics have been introduced, and combinations of antibiotics or antibiotics with sulfa drugs are currently gaining acceptance. These attempts are all directed toward obtaining the ideal antibiotic, or the ideal combination of antibiotics with other chemotherapeutic agents, in the hope of minimizing the emergence of resistant strains of pathogenic bacteria as well as the adverse effects upon the patient host.

Phenoxymethyl Penicillin (Penicillin V). This antibiotic is structurally similar to penicillin G, differing only in that a phenoxymethyl, rather than a phenylmethyl, group is attached to the basic structure of penicillin. It differs chemically from penicillin G in that it exhibits a high degree of stability in the presence of gastric juice. At a neutral or an alkaline pH it is converted to a readily soluble form. It is thus more completely absorbed following oral administration than is penicillin G. Penicillin V is produced biosynthetically by Penicillium Chrysogenum Q176. The antibacterial spectrum of this antibiotic is practically a duplicate of that of penicillin G. However, at present some strains of organisms appear to be considerably more sensitive to penicillin V than to penicillin G. As would be expected, cross resistance between the two antibiotics does exist.

Absorption, distribution and excretion: The oral administration of 200,000 units of penicillin V results in a more rapid, higher, and somewhat more persistent blood level than would occur from a comparable oral dose of penicillin G. Penicillin V does not readily gain access to the cerebrospinal fluid. However, like penicillin G, it penetrates the blood-brain-barrier more rapidly in the presence of meningeal inflammation. It is excreted in bile in an active form. It is eliminated in the urine and is excreted from the blood chiefly by the renal tubules. Probencid (Benemid), administered simultaneously with penicillin V, enhances and prolongs the blood level of this antibiotic by blocking renal tubular excretion. Some workers have demonstrated that following the oral administration of penicillin V the blood level may be 1.7 to 2.8 times that of a comparable dose of penicillin G administered orally in equivalent amounts as the potassium salt.

Penicillin V appears to be useful in the treatment of many infections involving penicillin-sensitive organisms. Though it is effectively absorbed orally, perhaps one should not rely upon this mode of administration for treating serious infections, especially when it cannot be certain that full and regular therapeutic doses will be taken by the patient.

While it has been reported that penicillin V produces fewer reactions than penicillin G when taken orally, penicillin V has not been employed sufficiently long and extensively to be certain of this. The chief advantage of penicillin V over penicillin G is that penicillin V is more effectively absorbed by the oral route, resulting in a higher and somewhat more persistent blood level.

Novobiocin (Streptonivicin, Cathomycin). Novobiocin is a new antibiotic which is especially effective against micrococci. It is known by a variety of names and is apparently produced by several different types of streptomyces. Streptonivicin is produced by Streptomyces niveus and cathomycin by Streptomyces spheroides.

These antibiotics are identical and are known by their generic name, Novobiocin. The structural formula is illustrated at the top of page 98.

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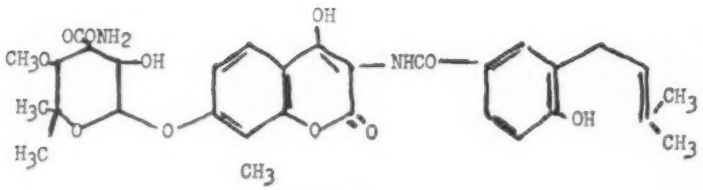


NOVOBIOCIN

Novobiocin is an acidic compound and is stable under pH conditions which obtain in the gastrointestinal tract. It can be converted into the sodium salt, and as such is freely soluble in water.

Antibacterial spectrum and organism sensitivity: Laboratory animals have been protected against a variety of infectious bacteria with novobiocin. It is active against several Gram-negative and Gram-positive organisms but is chiefly effective against micrococci. The minimal inhibitory concentrations for many strains of Micrococcus aureus vary between 0.19 to 3.1 micrograms per ml. Novobiocin has been employed effectively in treating infections involving micrococci which had developed resistance to several other antibiotics.

The recommended dose of novobiocin is 1 gram initially followed by 250 mgm. every 6 hours or 500 mgm. every 12 hours by mouth. There is increasing evidence that sensitive organisms may become resistant to this antibiotic on repeated exposure. Such resistance has been produced *in vitro* by repeated serial transfers.

Absorption, distribution, and excretion: Novobiocin is rapidly absorbed following oral or intramuscular administration. The oral route is preferred, since it is irritating when administered intramuscularly. After a dose of 500 mgm. by mouth, peak blood levels of 25 to 50 micrograms/ml. are obtained with 1 to 6 hours. Effective blood levels are maintained for about eight hours and trace amounts as long as 24 hours. There is marked variation in individual rates of absorption and blood levels.

When novobiocin is administered on an empty stomach it appears to be more rapidly and more completely absorbed. Maximal serum levels tend to stabilize quickly, so that a single oral dose of 500 mgm. may give the same maximal blood level as would be obtained following repeated doses of this magnitude. It is distributed to most body fluids, including pleural and ascitic fluids, but not the cerebrospinal fluid. It is bound by the serum proteins to a rather high degree, in which form it is antibiotically inactive.

Novobiocin is excreted in the urine, but only 5 per cent of a total dose is eliminated in an active form over a 24 hour period following a single oral dose. In the presence of renal insufficiency it tends to accumulate, resulting in higher blood levels and a correspondingly decreased rate of renal excretion. It is also concentrated in the liver and excreted in bile to some extent.

Toxicity and side effects: On the basis of laboratory experiments, novobiocin has a rather low order of toxicity and the therapeutic index is quite broad. It produces neither renal nor hepatic toxicity. A yellow pigment may appear in the plasma of patients treated with this agent, but this is thought to be a harmless metabolic by-product. This may interfere with the quantitative estimation of bilirubin and the icteric index.

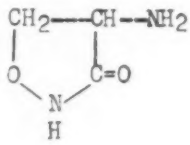
REDUCES WHITE CELL COUNT

When full doses of novobiocin are employed clinically the chief side effects are skin reactions, especially urticaria and a maculopapular rash. The incidence of allergic dermatitis is about 10 per cent. This may be reduced by limiting the daily dose to 500 mgm. A reduction in the white cell count considerably below the normal has also been noted. Mild gastrointestinal irritation may occur, causing nausea, abdominal cramping, and an increased number of stools, usually of liquid consistency.

Cycloserine. Cycloserine is a relatively new broad spectrum antibiotic produced by Streptomyces orchidaceus. While it is effective against a rather wide variety of both Gram-positive and Gram-negative bacteria, it is not especially potent. It is of especial interest as an antitubercular agent and has enjoyed rather broad clinical trials in the treatment of tuberculosis of many types. The results to date are encouraging.

Chemistry: Cycloserine is a white crystalline solid with a low molecular weight, 102. It is soluble in water to the extent of 10 per cent. The dry substance is stable at room temperature and withstands heating to 100° C. It is unstable when heated in solution. It is amphoteric but more stable in an alkaline solution than in acid solution at room temperature.

Absorption, diffusion and excretion: Cycloserine is rather rapidly and effectively absorbed following oral administration, appearing in the blood



Cycloserine
(D-4-amino-3-isoxazolidone)

within one hour. Experiments in laboratory animals suggest that it is absorbed from the stomach as well as from the intestines. It diffuses readily to all body fluids and tissues, including the sputum, pleural and ascitic fluid, cerebrospinal fluid, and also the anterior chamber of the eye. It also crosses the placental barrier. It appears in human milk. Repeated doses of 250 mgm. every four hours will produce a maximal serum level of 34 micrograms per ml. The content in cerebrospinal fluid determined simultaneously is almost equally as high. It is readily excreted in the urine in a biologically active form. The concentrations in the urine are of such magnitude as to permit its use as a urinary antiseptic, if the infection is due to susceptible organisms. Doses of 250 mgm., administered repeatedly, will afford a maximal urine concentration of 152 micrograms per ml. It is not excreted in the stool.

Toxicity and side effects: Acute and chronic toxicity studies on laboratory animals indicate that cycloserine is relatively nontoxic. The intraperitoneal LD50 in mice is 2.87 grams per kg. of body weight. It is said not to induce allergic sensitivity reactions in man. Therapeutic dose ranges in experimental animals are devoid of any significant pharmacodynamic effects. Therapeutic doses in man may produce central nervous system depression or stimulation. The most important

(*Continued on Page* 102)

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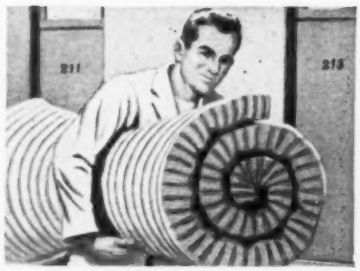

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(*Continued From Page 98*)

untoward effect is epileptiform seizures. The incidence and severity of seizures is definitely related to dose. When the dose does not exceed 1.5 grams per day or when this total daily dose is gradually achieved by starting with smaller daily doses considerably smaller than 1.5 grams, the incidence of convulsions is diminished.

Therapeutic applications: Cycloserine has been tried in a variety of nontuberculous infections with some success, but it does not appear to have any special advantage over some of the better known antibiotics. As a tuberculostatic agent, it appears to have a great deal of promise, either when employed alone or in combination with isonicotinic acid hydrazide, streptomycin or PAS. As an antituberculous agent it represents a sort of an antibiotic paradox in that experimental animals infected with the tubercle bacillus did not respond well to this agent. In man, however, it was demonstrated to be quite effective.

On the basis of this paradox, a host factor has been invoked to explain the differences in response. It is postulated that in human beings, in contrast to experimental animals, the compound is either altered by degradation or synthesis into a more potent tuberculostatic agent than can occur in laboratory animals, chiefly the guinea pig. A concentration of 5 to 25 micrograms per ml. will inhibit the growth of most strains of tubercle bacilli in man, including those resistant to other antitubercular agents. The plasma and tissue levels following daily oral doses of 0.75 to 1.0 grams varies between 10 and 50 micrograms per ml. Doses of 1 to 1.5 grams per day are more commonly employed, either alone or in combination with streptomycin or isonicotinic acid hydrazide therapy. Resistant strains of the tubercle bacillus have not been developed, either clinically or *in vitro*. The chief disadvantage of cycloserine as a tuberculostatic agent is that it may produce epileptiform seizures in a fair number of patients receiving therapeutic doses. It is much too early to predict what the ultimate status of this antibiotic will be, but at present it seems to complement those antituberculous agents which constitute standard drug therapy for this disease.

Oleandomycin (Matromycin, PA-105). Oleandomycin is a new crystalline antibiotic derived from Streptomyces antibioticus. While its chemical structure has not been disclosed, it has been shown to be different from any other known antibiotic. The empirical formula is $C_{37}H_{67}NO_{13}$. It is basic in reaction and can be converted into the hydrochloride form. The hydrochloride is extremely soluble in water and quite stable under pH conditions which obtain in the gastrointestinal tract.

TREATMENT OF INFECTIONS

Oleandomycin is chiefly effective against Gram-positive bacteria, but is also active against Neisseriae, Hemophilus, certain mycotic and viral infections, as well as some protozoa. It has been employed successfully in the treatment of human infections due to staphlococci, streptococci and pneumococci. It does not exhibit cross resistance with any of the commonly used antibiotics. Repeated exposure of bacteria sensitive to oleandomycin results in a very slow rate of emergence of resistant strains. Noyes and associates made a comparative study of the antibacterial effects of novobiocin and oleandomycin, both *in vivo* and *in vitro*. Of 100 strains of Staphlococcus

aureus resistant to penicillin and streptomycin, 95 per cent of these retained their sensitivity to oleandomycin and novobiocin. However, resistant strains developed considerably more rapidly for novobiocin than with oleandomycin.

While oleandomycin has been demonstrated to be an effective antibiotic in its own right in the treatment of infections involving sensitive organisms, its action is synergized when combined with the broad spectrum antibiotic tetracycline (67 per cent tetracycline and 33 per cent oleandomycin base). Not only are the antibacterial effects enhanced, but the development of resistant strains of bacteria, especially staphylococci, is greatly retarded.

Oleandomycin is readily absorbed following oral administration and high and effective blood levels may persist for as long as eight hours. Absorption is greatly diminished when given simultaneously with aluminum hydroxide gel. This is most likely due to adsorption of the antibiotic by aluminum hydroxide gel in a manner similar to that for the tetracyclines. This antacid should not, therefore, be administered with oleandomycin or tetracyclines.

There have been few side effects of any significance reported from the use of either oleandomycin alone or in combination with tetracycline. The recommended oral dose of oleandomycin is 1 to 2 grams daily, divided and administered at intervals of six to eight hours. Experimental animals that received repeated oral doses of oleandomycin, much in excess of the therapeutic dose, showed mild and reversible fatty infiltration of the liver. There was also a mild but reversible depression of the formed elements of the blood. Such findings have not been reported from the clinical use of oleandomycin. Like all broad spectrum antibiotics, a combination of oleandomycin with tetracycline may give rise to superinfections involving nonsusceptible organisms when used over an extended period of time.

PROPERTIES OF VANCOMYCIN

Vancomycin. Vancomycin is a new antibiotic derived from Streptomyces orientalis. It is amphoteric and will thus form salts with both acids and bases. The hydrochloride, a white solid, is extremely soluble in water (100 mgm./ml.) and is relatively stable. Its chemical structure has not been determined. It has a molecular weight of 3300.

Antibacterial actions: Vancomycin is both bacteriostatic and bactericidal, depending upon the concentration and the sensitivity of the organisms. However, the bacteriostatic concentration is quite close to that needed for a bactericidal action. Vancomycin is highly effective against micrococci, especially when they are in the phase of rapid multiplication. *In vitro* sensitivity studies showed it to be effective in concentrations varying between 0.156 and 2.5 micrograms per ml. against Streptococcus hemolyticus, Strep. viridans, Strep. pneumoniae, Micrococcus pyogenes var. albus, Sarcina lutea, and Strep. faecalis. Mice have been protected from experimental infections involving Micrococcus pyogenes, Streptococcus pyogenes, Diplococcus pneumoniae, and Borrelina novyi, when the antibiotic was administered intravenously. The antibiotic activity of vancomycin is not materially altered over a pH range of 6.5 to 8.0. While resistance *in vitro* can be produced by repeated serial transfers of sensitive organisms, it develops comparatively slowly. Some strains of Micrococcus pyogenes have been made

resistant to 17 times the original bacteriological concentration by serial transfer for 28 times.

Routes of administration, absorption and excretion: Vancomycin is not absorbed following oral administration. It exhibits a local bactericidal effect in the intestinal tract, especially on micrococci and certain other Gram-positive organisms but not Gram-negative bacteria. Though effective blood levels can be obtained following intramuscular administration, the antibiotic produces mild local pain when given by this route. It produces a low incidence of adverse effects when administered by vein, and this is currently the preferred route of administration. The intravenous administration of doses of the order of 50 to 100 mgm. will produce a blood level of 0.5 to 1.6 micrograms per ml. or higher during the first two hours. This will remain as high as 0.8 micrograms per ml. up to six or eight hours. Repeated intravenous doses of 500 mgm. every six hours will produce high blood levels, 33 micrograms per ml., gradually declining to 0.7 micrograms per ml. 24 hours after the last dose. It readily diffuses into pleural, pericardial, ascitic and synovial fluid but not into the cerebrospinal fluid. It is excreted in rather high concentrations in the urine. An intravenous dose of 500 mgm. will afford urinary levels of 110 to 170 micrograms per ml. Practically none can be detected in the urine following oral administration, but high concentrations appear in the stool.

Toxic effects: Vancomycin is relatively nontoxic. Therapeutic doses in man occasionally produce chills, dermatitis and varying degrees of phlebitis when administered intravenously.

This antibiotic has not had sufficient clinical trial to make certain its ultimate status among antibiotics or the degree with which it might produce side effects. On the basis of studies to date, it would appear to be of great value in the treatment of Micrococcus ileocolitis when administered orally, and systemic micrococcal infections when administered intravenously. It may also be useful in controlling infections involving vancomycin-sensitive organisms which have become resistant to other antibiotics. Vancomycin displays no cross resistance with penicillin, streptomycin, neomycin, bacitracin, novobiocin, chloramphenicol, or erythromycin.—THEODORE R. SHERROD, PH.D., M.D.

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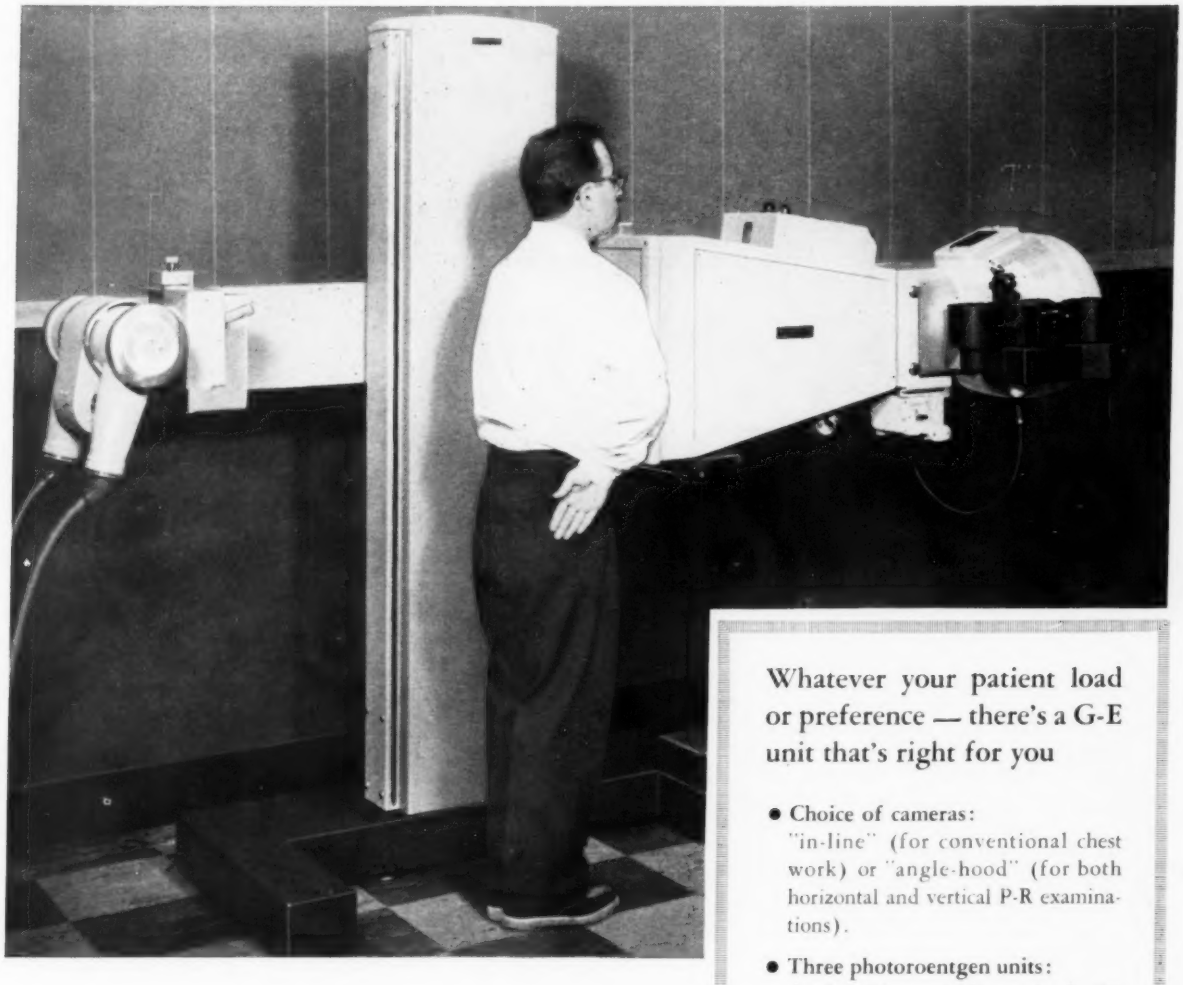

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ROBERT P. LAWTON

A TYPICAL dietary department in a general hospital today has an annual operating cost totaling about $1000 per adult bed. This means that the chief dietitian of a 50 bed hospital is directing a $50,000 per year business; in a 150 bed hospital, a $150,000 per year business, and in a 200 bed institution, a business averaging $200,000 a year.

In addition, it must be remembered that these are *cost* figures. If we add a conservative 50 per cent to these costs, to make the operation comparable to that of a profit-making restaurant, then the chief dietitian of the 150 bed hospital is running a $225,000 per year restaurant and the dietitian of a 200 bed hospital is operating a food service department comparable to a private enterprise grossing nearly one-third of a million dollars per annum.

Hospital administrators and dietitians often are unaware of the size of their food service business and, more often, neglect good business practices that would be mandatory in a restaurant of equal size. An analysis of dietary expenses in seven Connecticut hospitals, in the 100 to 250 adult bed range, disclosed that on the average 20 per cent of the hospital's expense is in the dietary department. A further breakdown in these same hospitals discloses that 48 per cent of this departmental expense, or 9.6 per cent of the hospital's total expense dollar, is in payroll to dietary employes. The study also shows that 44 per cent of the dietary expense dollar, or 8.8 per cent of the total hospital outlay, is spent for raw food purchases. The balance of the food service expense dollar, 8 per cent, is in heat, fuel, supplies and all other dietary expense, representing 1.6 per cent of the total hospital expenditures.

Among the seven hospitals, salary expense, in terms of total dietary expense, ranged from 41.5 per cent to 52.9 per cent. The cost of raw food ranged from a low of 37.3 per cent to a high of 53.5 per cent.

Mr. Lawton is administrator, Danbury Hospital, Danbury, Conn.

KNOW DIETARY COSTS

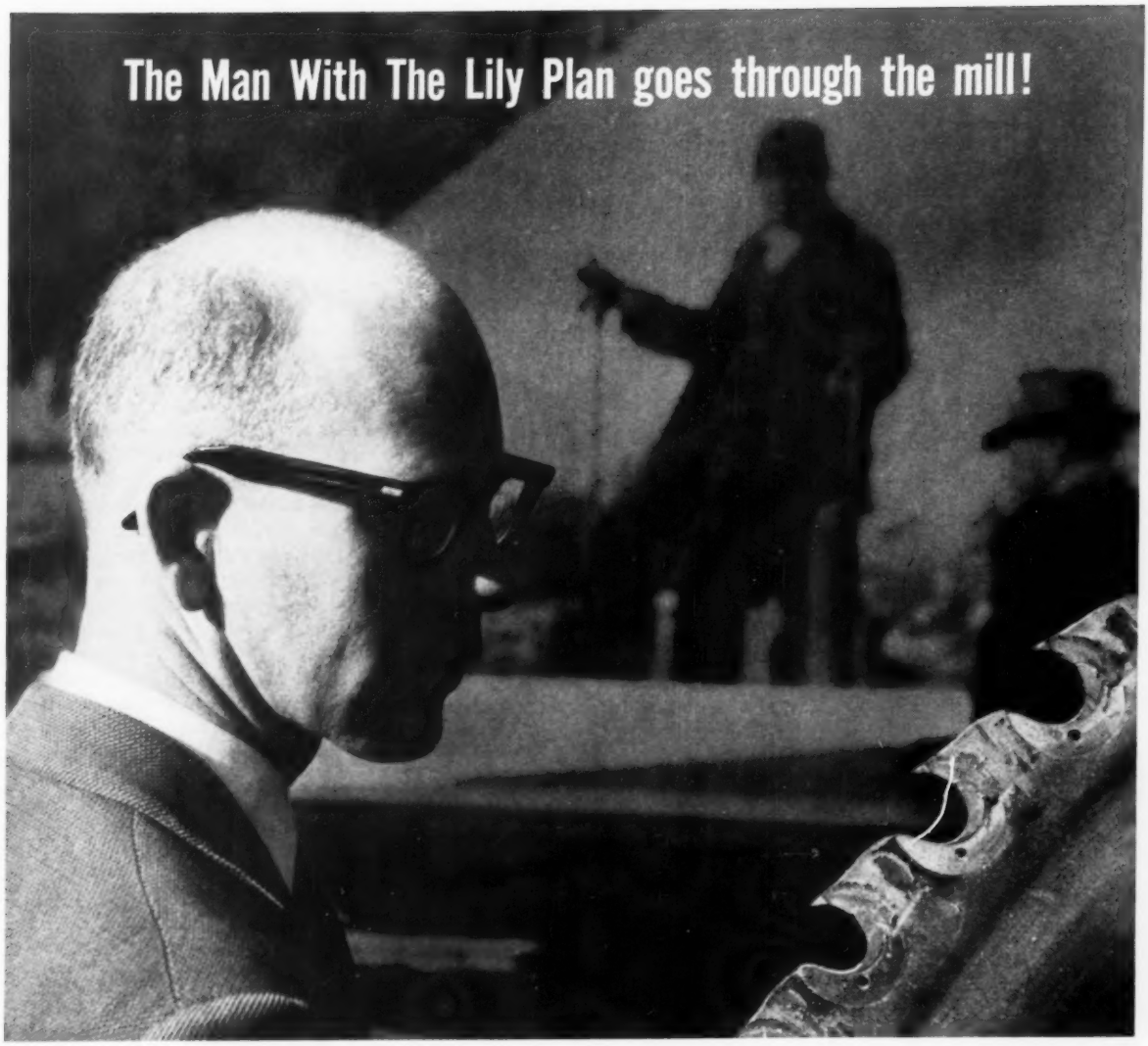
Today's dietitian must recognize that the cost of hospitalization to the patient is high and that hospitals everywhere are fighting for the principle of reimbursement on the basis of their costs. Therefore, the dietitian and the hospital must know their dietary costs and are responsible for holding them to a reasonable level.

The dietitian should not hesitate to take to her administrator a detailed, complete and businesslike plan for the operation of her department. She should not hesitate to propose a departmental budget and a plan for a dietary cost control system. She should not be afraid to recommend additional clerical help if it is necessary to achieve accurate food cost accounting. An efficient system of dietary cost control, even if it demands additional part-time accounting help, will probably result in a net saving in the operation of the hospital's food service.

The three categories of departmental expense are: (1) the cost of labor; (2) the cost of raw food, and (3) supplies, fuel and all other expense. Let us recall that these are, respectively, 48 per cent, 44 per cent and 8 per cent of the dietary department's expense dollar. Let us also remember that $1 out of every $5 spent by the hospital is expended in the dietary department.

It is the intent here to give the principal emphasis to the control of raw food costs, but let us look briefly at labor costs and the cost of overhead and supplies.

It is most important to set up a fixed personnel complement. It is necessary also to write the job specifications for each employe in the dietary department to guarantee a full eight hours of employment in each worker shift. Many hospitals are finding it difficult to retain the split shift system (using one dietary worker to cover all three meals in the hospital day) and must adjust their work system and job specifications to justify hiring workers on the straight eight-hour shift the labor market may require. One desirable solution to the problem of a necessary straight shift is to develop greater centralization of food service activities, *i.e.* to combine into one service kitchen or pantry the responsibility for serving two or more patient areas, instead of relying on one kitchen or pantry per area. Seventy beds have been served efficiently from one service kitchen on a decentralized basis, and 50 is not uncommon. A slight additional distance problem can be overcome by efficiency. The building up of the jobs normal to a food service pantry that has been enlarged to cover a great



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Lily cups

number of beds makes these jobs big enough to justify the straight shift salary expense and enables the hospital to hold its total personnel complement to what it was on a split shift basis. The dietary department has more difficulty than most departments in compensating for unanticipated absence from illness or any other cause. One cannot laugh off dirty dishes!

To prevent a breakdown of service, it is desirable to include the proper number of floating dietary employes in every food service department. This should be a reasonably low number of persons who can fill the emergency job vacancies when there is an unanticipated absence. The floats should not be allowed to become permanently attached to any one job if there are no certain vacancies for them to fill. This is not generally a problem if the hospital is of appreciable size.

The basic cost of heat, fuel and other items of overhead is probably already built into the dietary department. Therefore, there is probably little that can be done to change them if you are not planning new construction, but these fixed cost items cannot be neglected or the waste of either heat or fuel condoned.

MACHINES SAVE MONEY

As far as dietary equipment is concerned, the dietitian should see that her department is using modern labor saving machines. Almost invariably it pays to replace personnel with machines of this type. The rapidity with which savings in payroll offset the cost of a desirable piece of equipment has amazed everyone who has ever stopped to calculate it. For example, 20 weeks of a dietary maid's salary will buy a commercial dishwashing machine of good capacity, and only a few weeks of her salary will pay for a silver burnishing apparatus. In addition, standard hospital accounting permits the cost of permanent equipment to be amortized over a period of many years. The hospital's operating expense is charged annually only with the amortization, making an even more favorable contrast in relation to the salaries of workers labor saving machinery replaces.

Many labor saving machines have the added advantage of standardizing portions, so important to food cost control. As an example, the ice cream scoop is the simplest device to give the dietitian this advantage. It is ideal for mashed potatoes, rice, puddings and other desserts, and a variety of other foods. The meat slicer removes the element of human error in standardizing portions. The potato peeler is a sure-fire cost saver even though it may not remove the eyes.

The trick to economy in the field of semiconsumable equipment is standardization of items such as dishes, silverware and dietary utensils. One pattern of dishes per hospital is the only really practical system. One should not be afraid to try out plastic dishes. The hospital laboratory can determine how sanitary such dishes are by making its own cultures and analyses. Plastic dishes are the most economical an institution can use from the point of view of low replacement cost, and they are favorably received by patients. The stain problem can be overcome.

STANDARDIZE ON PORTIONS

The hospital should standardize on items of glassware and dishes that will give small, controlled portions of foods. Some examples are the small fruit juice glasses, standard sherbets, sauce dishes, nappies, and even plates. While it is the standard size for each food item that forces the employe serving food to adhere to rigid portion control, the dietitian need not be ashamed to take advantage of a plate, dish or piece of glassware that is smaller than the one the hospital has been using for years. It is more pleasing to the patient to have a small portion of food attractively served than it is to have a lot of food served unattractively in a dish, plate or glass that is too large. Except for maternity patients and hospital personnel (especially interns), those served food in hospitals desire relatively small portions. Too many hospitals are guilty of overserving, thus wasting food and, consequently, the patient's money.

The salient points in a system of controlling raw food costs are these:

1. Calculate the hospital's total food expense periodically, in advance.
2. Fit the future menus into an official, approved budget.
3. Maintain a leakproof requisition and issue system.
4. Check your actual costs promptly at the end of a budget period.
5. Standardize items, packages and portions.
6. Put all issuing of food under the control of the head dietitian.

Calculating the raw food costs before the food is served is perhaps a somewhat tedious and disagreeable exercise in arithmetic. The dietitian, however, should not let this scare her, for there is no way of avoiding this particular step. The secret to any system of food service control is to find out *before* food is served what its cost actually is. There are a variety of ways to determine this, so far as blank forms and individual systems are concerned. I will discuss one way of doing it and show how one particular piece of paper is the key to advance food cost calculation. Different forms can be used, but the basic principle is the same.

When the hospital dietitian or her assistant has determined the menu for a week, she transfers every item of food on that menu to what we'll call the food service control record. This record, a sample of which is reproduced on page 110, is a multi purpose form that can be used for raw food cost determination, final actual food cost report, requisition and inventory record.

The dietitian inserts in the column headed "Quantity Issued" (See sample form) the number of units of each food item needed to serve the hospital's weekly menu to the estimated number of patients and other diners. She applies a unit price that is either the last price she herself paid, if she is the food purchaser, or a price supplied to her by the purchasing department if it buys the food supplies.

HOW TO USE CONTROL SHEET

The standard food items stocked and customarily used by the hospital are printed on a control sheet with a liberal number of blanks, which permits the dietitian variations in her menu and allows her space to insert the food items not printed on this record. The columns of estimated quantity and unit prices are extended into the amount column, and the total cost of all food to be served under this menu for a week is brought down to the grand total column on the reverse side. One look at this figure will tell the dietitian who is used to this system whether the menu is too large to fit into the budget. However, she should always check it on the basis of the estimated number of meals to be served to make sure that her calculations in terms of per diem ration costs are accurate.

To determine the estimated number of daily rations by which the grand total of raw food expense must be divided, the census of inpatients in the hospital is estimated on the basis

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FOOD SERVICE CONTROL SHEET

Date _____

Ord.	ARTICLES	Quantity Issued	Unit Price	Amount
	BAKED GOODS			
	Bread			
	Cookies			
	MEATS, POULTRY			
	Beef lb.			
	Lamb lb.			
	Pork lb.			
	Veal lb.			
	Cold Meats lb.			
	Frankfurters lb.			
	Fryers lb.			
	Chicken lb.			
	Turkey lb.			
	FISH			
	Salmon 4 lb. can			
	Salmon 1 lb. can			
	Tuna 4 lb. can			
	Tuna 1 lb. can			
	DIABETIC FOODS			
	Applesauce 2's			
	Apricots 2's			
	Cherries 2's			
	Fruit Cocktail 2's			
	Grapefruit 2's			
	Peaches 2's			
	Pears 2's			
	Pineapple 2's			
	Plums 2's			
	Jelly 12 oz.			
	No Cal Gingerale btl.			

Ord.	ARTICLES	Quantity Issued	Unit Price	Amount
	DAIRY PRODUCTS			
	Butter, Chips lb.			
	Butter, Sweet lb.			
	Cheese, Brick lb.			
	Cheese, Cheddar lb.			
	Cheese, Cottage lb.			
	Cheese, Cream lb.			
	Cheese, Grated lb.			
	Cheese, Ind'v'l Box			
	Cheese, Old Nat'l lb.			
	Cheese, Sliced lb.			
	Eggs doz.			
	Milk & Cream			
	Oleomargarine lb.			
	Ice Cream Mix gal.			
	CANNED VEGETABLES			
	Asparagus 2's			
	Beans, Baked 10's			
	Beans, Green 10's			
	Beans, Red Kidney 5's			
	Beans, Wax 10's			
	Beets, Sliced 10's			
	Cabbage, Red Sour 10's			
	Corn, Cr. 10's			
	Corn, W. K. 10's			
	Onions, Boiled 10's			
	Peas 10's			
	Peas 2's			
	Potatoes, Swt. 10's			
	Potatoes, Swt. 5's			
	Pumpkin 10's			
	Sauerkraut 10's			
	Sauerkraut 5's			
	Tomatoes 10's			
	Tomatoes 2½'s			
	Tomato Puree 10's			
	Vegetables, Mixed 10's			
	SALT FREE			
	Asparagus 2's			
	Beans, Green 2's			
	Beans, Wax 2's			
	Carrots 2's			
	Peas 2's			
	Tomatoes 2's			
	Salmon 7¾ oz.			
	Tuna 6½ oz.			
	Bouillon Cubes ea.			
	Soup 32 oz.			
	Pudding 22 oz.			

Ord.	ARTICLES	Quantity Issued	Unit Price	Amount
	FRESH VEGETABLES AND FRUITS			
	CANNED FRUITS			
	Apples 10's			
	Applesauce 10's			
	Applesauce 2's			
	Apricots, Whole 10's			
	Apricots, Whole 2½'s			
	Apricots, Halves 10's			
	Apricots, Halves 2½'s			
	Cherries, R.S.P. 10's			
	Cherries, R.A. 10's			
	Citrus Mix 5's			
	Figs 10's			
	Fruit Cocktail 10's			
	Grapefruit 5's			
	Mandarin Oranges 11½'s			
	Peaches, Halves 10's			
	Peaches, Halves 2½'s			
	Peaches, Sliced 10's			
	Peaches, Sliced 2½'s			
	Peaches, Elberta, Cut 10's			
	Pears 10's			
	Pears 2½'s			
	Pears, Diced 10's			
	Pineapple, Chunks 10's			
	Pineapple, Cr. 10's			
	Pineapple, Sl. 10's			
	Prune Plums 10's			
	Rhubarb 10's			
	FROZEN VEGETABLES			
	Asparagus, Cuts pkg.			
	Asparagus, Spears pkg.			
	Beans, Green pkg.			
	Beans, Lima pkg.			
	Beans, Wax pkg.			
	Broccoli pkg.			
	Brussels Sprouts pkg.			
	Cauliflower pkg.			
	Corn, Cut pkg.			
	Mixed Vegetables pkg.			
	Peas pkg.			
	Spinach pkg.			
	Squash pkg.			
	FROZEN FRUITS			
	Apples pkg.			
	Cherries, R.S. pkg.			
	Strawberries pkg.			

Front of record. On reverse side is space for grand total of costs, estimated daily meals, and cost per person.

of the census in the immediately preceding weeks and also upon the census for the same period of the preceding year, if the hospital is subject to seasonal variation in patient load. To this number of persons to be served daily as patients, she may add the most accurate estimate that retained records can give her of the number of employes who will take their meals in the hospital cafeteria. The total of these two numbers is divided into the total estimated food cost. This yields a result which is the per diem raw food cost for one person or the cost of ration per day. Meals for the staff can be calculated separately. This is a figure that will generally range between 90 cents and $1.25. It should be related to the department's budget to determine if the menu is too rich in terms of budget expense.

The cost of between-meal refreshments for patients and the cost of

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infant formulas are included in the food items that are priced and totaled, but no rations are added to the estimated number for these two elements of food service. If infant formula is not under the dietitian's direction, she omits this item from her cost analysis. The per diem ration budget which the hospital administration approves for the food service department is determined by the current cost of all types of raw food, the community in which the hospital is located, the types of diet, and the quality and variety of food service the hospital wants.

The amount of this food cost budget for all the food served to a patient in one day should be adjusted periodically, perhaps every four months, to reflect changes in the food cost index, and it may be adjusted at the discretion of the hospital in order to achieve deliberate variations in the amount or quality of food served. For example, if there are patient complaints that the quality of food is not sufficiently good, or that the variety is unsatisfactory, the hospital can improve variety and quality by raising the amount of the per diem budget which the dietitian may spend. The important thing is to have this budget figure predetermined, officially approved, and to use it as a check on the menu when it is prepared by the dietary department.

No raw food cost control system can function efficiently without a foolproof system of requisitioning and issuing raw food supplies to the various dietary department areas where they are prepared or consumed. This merely means that all foodstuffs are kept in proper storage locations, and are never withdrawn without a proper requisition, and that the requisitions are filed in a central place, available for computation of the total value of raw food used in any budget period.

TWO FOOD STORAGE AREAS

A common system would be to keep all dry foods under central stores' control as a part of the purchasing department and all perishable foods under the dietitian's control, stored in an area near the main kitchen. No item should leave central storage without an authorized signature of the dietitian or a designated assistant. This prevents main kitchen personnel, for example, from running down to the storeroom to pick up this or that without a record being made. Central storeroom keys should not be kept by dietary department employes, except for an emergency key for the charge dietitian. There may be variations to this system, but they must be leakproof and efficient.

Perishable foods stored in the dietary department must be controlled by a requisition and issue system directed by the dietitian or her assistant in charge of the main food preparation area. This can be accomplished by use of a requisition, although in many hospitals it is practical, since no perishable foods are stored in excess of those to be used in one week's menu, to charge the entire quantity of that week's perishable food expense from the invoices. At the end of the food cost accounting period, the value of any inventory left in refrigerated storage is credited. Larger hospitals will have a breakout storeroom for dry groceries, making it possible to withdraw groceries from the central stores department at less frequent intervals. If this is the case, the quantities of food withdrawn from this substorage area for dry food must be rigidly controlled by either a requisition or an inventory at the end of each cost control period.

(*Continued on Page* 114)

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(*Continued From Page* 112)

At the end of the period for which the menu has been prepared, usually a week in the most practical system, all of the requisitions for raw food, whether perishable or nonperishable, are gathered in the dietitian's office and transcribed to one copy of the food service control sheet. This is a straight tabulating job which can be done with relative ease—exactly the same process by which the estimated raw food expense for the week was calculated except that, in this instance, the actual quantities of food withdrawn and consumed are inserted on the record and the result is the actual raw food cost for the week. This total is divided by the *actual* number of per diem rations served in the week in question and the *actual* cost of each ration per day is thus determined.

The number of actual daily rations is determined by adding the total adult and pediatrics census for each day to the total number of persons served in the cafeteria. If the cafeteria is not operated for cash, an actual physical count of the diners or the total number of tickets collected from employes can be substituted for the usual cash register tabulation.

If the estimated cost of the menu was carefully calculated and variations were not made in the menu, and if the total number of rations served was accurately predicted in advance, the per diem ration cost as determined on the estimated analysis and that on the final accounting will be the same. They will rarely be alike to the fraction of a cent but they should not vary more than a few cents. If they vary greatly, the dietitian can compare her estimated analysis and the actual analysis to determine where her estimates were in error or where there might have been a marked fluctuation in price and can so benefit from this experience. Inaccurate guesses as to census and the number of persons served in the cafeteria will unquestionably arise. This has little bearing on the final result and should not produce gross variations since we are comparing a figure which represents only the cost of the food served to one person in one day.

GIVE REPORTS TO ADMINISTRATOR

Both the estimated control sheet and the actual control sheet should be submitted as soon as prepared to the administrator, with a copy retained by the dietitian. The purpose of submitting the estimated control sheet is solely one of procedure to guarantee that the advance calculation is made. There is no *real* cost control unless this estimate is made beforehand.

There are variations of this basic system that can be utilized with satisfactory results. For example, a running record on a long form requisition of all the items of food issued in a week can be kept, priced and totaled at the end of the week and divided by the number of per diem rations. This is just another way of accomplishing the same thing as filling out the sample cost control sheet at the end of the food service period and yields the same results. Any accurate system of recording all the food issued and consumed during the period covered by a menu is of course satisfactory. The small hospital can adapt its paper work to the time and ability of the available personnel. There is no substitute, however, for an advance calculation of what the food to be served on the menu will cost, because it is the only way *real control* can be achieved. It is an unsatisfactory system when the dietitian prepares menus which "look right" from the cost standpoint only

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to find that she went way over the budget. This may prompt her to be more cautious during the next menu period, but it is really a story of locking the barn after the horse is gone.

The final essential element in good raw food cost control is the use of standard items of food in standard packages, served in standard portions. The sample control sheet can be varied almost at will so long as one accepts the principle that items will not be added just because they strike someone's fancy. If there are enough foods, excluding perishables, on the standard stock list the menu will have enough variety. There are untold economies to be gained in having a standard list and sticking to it. Perishables are subject to more variation, of course, to take advantage of foods during their plentiful season.

There is obvious efficiency in having standard packages so that the same unit price can be used in all food cost accounting practices and for convenience in purchasing. Any commonsense unit will suffice. A can or bottle size can be used, as well as pounds and ounces. It is usually best to use the largest commercial package available. If a food item does not come in a standardized package then the pound should be the common denominator. It is sometimes dangerous to make a bargain purchase in a package size which differs from that on the hospital's standard list because it may complicate cost accounting and lead to unforeseen expense far in excess of any "saving" made on that particular bargain purchase. There is a neatness about standardization that is conducive to good cost control.

Portion control in terms of the weight or size of the actual portion of cooked food served to the patient is becoming more and more common, and it is more and more important in a good cost control system. If portioned meats are available and have come down in cost to the point where they are truly competitive, after the labor savings are calculated, the dietitian should not hesitate to use them. Another decade may well see all meats used in hospitals marketed by the packer or supplier in portioned units.

There are a number of food service "tips" many dietitians recommend as general basic policy for keeping food costs under control. Some of the more popular of these, reflecting current trends in hospital food service, are as follows:

1. Cut out frills and fancy food items or elements of service. The patient of today merely wants, and only wants to pay for, a reasonable amount and variety of food tastefully and attractively prepared.

2. Make full use of a master menu or some variation thereof. This offers an effective means of formulating the necessary special diets from those items of food on the regular diet for the day. A selective menu should have a small number of choices. One variation in entrée, one in vegetable, and one in beverage should be sufficient to satisfy even patients in the most expensive private accommodations. If patients elect items of food other than those on the selective menu which are not called for by their physician's order, they can be charged something approximating current restaurant prices for the special food item. A statement on the menu distributed in advance to patients that special foods not on menu will be charged at special additional prices on the bill is perfectly proper and generally reduces the number of such requests to a minimum.

3. Most hospitals have eliminated between-meal refreshments unless they are ordered to satisfy a fluid deficiency or some other problem in medical care. They should be served only on the *legitimate* order of the physician, and a good rule to follow is to treat between-meal refreshments as a medication in the sense that they are not a regular part of the hospital's food service. These things are pleasing to the patient when he consumes them, but he would usually rather not have them added to his hospital bill and they can represent a large, unnecessary item in food cost.

4. If the hospital is serving food on a decentralized system, under which the food is carried in bulk to service pantries and dished at that location, try to combine as many of these pantries as possible so that the total number of beds served by each pantry is greater than before. This results in a saving of labor, supplies and food and is generally much more efficient. It may be possible in adjacent patient areas to shut down one service pantry and serve both areas from the remaining one if distances are not too great. Think in terms of going back to something approximating the 50 beds per pantry discussed earlier in this paper in connection with budgeting personnel time and eliminating the split shift worker.

Menus for August 1957

Dorothy Bettenbrock
Chief Dietitian
Bethany Hospital
Kansas City, Kan.

1 Half Banana Scrambled Eggs • Tomato Rice Soup Shepherd's Pie Harvard Beets Marinated Cucumber Salad Gingerbread, Custard Sauce • Beef Barley Soup Grilled Pork Chop Steamed Potato Buttered Peas Grapefruit-Apple Salad Apricot Bavarian Cream	**2** Honeydew Melon Soft Cooked Egg • Clam Chowder Chinese Omelet Oven Browned Potato Corn on the Cob Sliced Tomatoes Strawberry Ice Cream • Cream of Pea Soup Baked Haddock, Lemon Baked Potato Julienne Carrots Stuffed Celery, Black Olives Cranberry Crisp	**3** Dried Fruit Compote Scrambled Eggs • Vegetable Soup Broiled Sweetbreads Mashed Potatoes Wax Beans Shredded Lettuce With Hard Cooked Egg Apple Dumpling • Cream of Tomato Soup Roast Pork Loin, Gravy Escalloped Potatoes Buttered Spinach Citrus Fruit Salad Butter Cookies	**4** Orange Half Soft Cooked Egg • Potato Soup Roast Beef, Gravy Oven Browned Potato Buttered Asparagus Fresh Fruit Salad Vanilla Ice Cream • Chicken Noodle Soup Cabbage Roll, Tomato Sauce Potatoes au Gratin Stuffed Prune Salad Blueberry Crumb Pudding	**5** Grapefruit Juice Scrambled Eggs • Scotch Broth Macaroni and Cheese Buttered Peas Chef's Salad Cottage Pudding • French Onion Soup Meat Loaf, Gravy Buttered Rice Buttered Broccoli Relish Plate Applesauce	**6** Fresh Peach Soft Cooked Egg • Cream of Celery Soup Hot Beef Sandwich, Gravy Whipped Potatoes Buttered Green Beans Perfection Salad Watermelon • Pepperpot Soup Barbecued Spareribs Parsley Potatoes Baked Squash Fresh Fruit Salad Blackberry Pie
7 Grapefruit Half Cinnamon Roll • Mulligatawny Soup Chow Mein Buttered Asparagus Cole Slaw Chocolate Brownie • Cream of Mushroom Soup Baked Ham, Applesauce Candied Sweet Potato Buttered Spinach Apple-Celery-Nut Mold Bing Cherries	**8** Stewed Prunes Soft Cooked Egg • Duchess Soup Ham à la King on Cornbread Buttered Carrot Rings Head Lettuce Graham Cracker Brown Betty • Vegetable Soup Veal Birds Diced Creamed Potatoes Mixed Vegetables Apricot-Nut Salad Lemon Meringue Pie	**9** Orange Half Scrambled Eggs • Potato Soup Egg Salad, Pimiento Cheese Sandwiches Potato Chips Chef's Salad White Cake, Chocolate Sauce • Cream of Tomato Soup Fried Cod, Tartare Sauce Potatoes au Gratin Buttered Asparagus Relish Plate Baked Custard	**10** Apricot Nectar Soft Cooked Egg • Beef Noodle Soup Broiled Chicken Livers Buttered Peas Potato Salad Raspberry Gelatin Cubes • Cream of Celery Soup Roast Beef, Gravy Hashed Brown Potatoes Buttered Lima Beans Pickled Beet Salad Oatmeal Drop Cookies	**11** Cantaloupe Slice Coffee Cake • Cream of Pea Soup Fried Chicken, Cream Gravy Mashed Potatoes Wax Beans Pear Salad Peach Dumpling • French Onion Soup Breaded Veal Steak Baked Potatoes Stewed Tomatoes Carrot Sticks, Pickles Macaroons	**12** Fresh Peach Soft Cooked Egg • Vegetable Soup Italian Spaghetti Tossed Salad, Vinegar and Oil Dressing Green Gage Plums • Chicken Rice Soup Broiled Liver, Onions Diced Creamed Potatoes Brussels Sprouts Waldorf Salad Fruited Gelatin
13 Pineapple Juice Bran Muffins • Corn Chowder Macaroni and Cheese Buttered Spinach Marinated Cucumber Salad Kadota Figs • Navy Bean Soup Deviled Pork Chop Whipped Potatoes Baked Squash Golden Glow Salad Butterscotch Chew	**14** Stewed Raisins Soft Cooked Egg • Beef Noodle Soup Hamburger on Bun, Onions, Relishes Oven Browned Potato Coleslaw Apricot Bavarian Cream • Cream of Celery Soup Breaded Veal Steak Baked Potato Breaded Tomatoes Spiced Crabapple Salad Baked Custard	**15** Seedless Grapes Scrambled Eggs • Split Pea Soup Stuffed Green Pepper, Tomato Sauce Steamed Potato Stuffed Celery, Olives Watermelon • French Onion Soup Glazed Corned Beef Escalloped Potatoes Steamed Cabbage Fresh Fruit Salad Jelly Roll	**16** Blended Juice Soft Cooked Egg • Cream of Mushroom Soup Salmon Casserole Buttered Asparagus Banana-Nut Salad Stewed Rhubarb • Cream of Tomato Soup Baked Halibut, Lemon Parsley Buttered Potato Wax Beans Head Lettuce, 1000 Island Dressing Cherry Pie	**17** Tomato Juice Scrambled Eggs • Duchess Soup Creamed Dried Beef on Toast Buttered Spinach Chef's Salad Pineapple Upside Down Cake • Pepperpot Soup Swiss Steak Oven Browned Potato Buttered Beets Relish Plate Chocolate Chip Cookies	**18** Banana Half Soft Cooked Egg • Beef Rice Soup Roast Turkey, Dressing and Gravy Whipped Potatoes Buttered Peas Tomato Wedge Salad Black Walnut Ice Cream • Chicken Broth Cheese Omelet Buttered Green Beans Stuffed Pear Salad Yellow Coconut Cake
19 Fresh Peach Scrambled Eggs • Cream of Pea Soup Chow Mein Creamed Spinach Lettuce Wedge, French Dressing Green Gage Plums • Washington Chowder Grilled Pork Chop Diced Creamed Potatoes Mixed Vegetables Citrus Fruit Salad Tropical Bread Pudding	**20** Cantaloupe Slice Soft Cooked Egg • Scotch Broth Creole Spaghetti Wax Beans Golden Glow Salad Lime Sherbet • Duchess Soup Broiled Liver, Onions Baked Potato Buttered Beets Spiced Apple Ring-Cottage Cheese Salad Chocolate Chiffon Cake	**21** Fresh Grapes Butterscotch-Nut Roll • Vegetable Soup Meat Pie Julienne Carrots Apple Pie, Cheese • Cream of Tomato Soup Meat Loaf, Gravy Whipped Potatoes Buttered Peas Bing Cherry Mold, Mayonnaise Chocolate Nut Drops	**22** Stewed Prunes Soft Cooked Egg • Lakeside Soup Baked Ham Parsleyed Potatoes Lima Beans Tomato Wedge Salad Watermelon Cream of Mushroom Soup • Barbecued Spareribs Potatoes in Cream Sauce Buttered Spinach Chef's Salad Blue Plums	**23** Grapefruit Half Scrambled Eggs • Potato Soup Tuna Loaf Oven Browned Potato Buttered Peas Marinated Cucumber Salad Peanut Butter Cookies • Tomato Rice Soup Fried Haddock Hashed Brown Potatoes Stewed Tomatoes Peach Salad Bing Cherries	**24** Banana Half Soft Cooked Egg • Mulligatawny Soup Beef Stew, Biscuit Topping Harvard Beets Coleslaw Chocolate Eclair • Beef Barley Soup Spanish Steak Whipped Potatoes Cauliflower au Gratin Tossed Salad Gingerbread, Custard Sauce
25 Grape Juice Scrambled Eggs • Pepperpot Soup Fried Chicken, Gravy Mashed Potatoes Buttered Asparagus Spiced Peach Salad Strawberry Ice Cream • Cream of Celery Soup Cottage Cheese, Canned Fruit Plate Buttered Green Beans Banana Bread Lime Gelatin Mold White Layer Cake	**26** Fresh Grapes Soft Cooked Egg • Bouillon Rosa Ham à la King on Cornbread Buttered Peas Chef's Salad Lemon Cake Pudding • Navy Bean Soup Swiss Steak Buttered Rice Corn on the Cob Banana-Nut Salad Apricot Halves	**27** Orange Juice Scrambled Eggs • Vegetable Soup Hamburger on Bun, Onions, Relishes Stewed Tomatoes Potato Salad Date Swirls • Beef Noodle Soup Chicken Pie Buttered Broccoli Fresh Fruit Salad Rice Pudding	**28** Apricot Nectar Bran Muffins • Corn Chowder Stuffed Green Pepper, Tomato Sauce Oven Browned Potato Head Lettuce, 1000 Island Dressing Rhubarb Pie • Chicken Rice Soup Baked Ham, Pineapple Escalloped Potatoes Buttered Carrot Rings Applesauce Mold Caramel Custard	**29** Fresh Peach Scrambled Eggs • Pepperpot Soup Swedish Meat Balls Whipped Potatoes Wax Beans Marinated Cucumber Salad Cheese-Apple Crisp • Mulligatawny Soup Grilled Pork Chop Steamed Potato Buttered Asparagus Pineapple Salad Butterscotch Pudding	**30** Blended Juice Soft Cooked Egg • Clam Chowder Salmon Casserole Buttered Peas Shredded Lettuce With Hard Cooked Egg Orange Sherbet • Cream of Tomato Soup Baked Haddock, Lemon Diced Creamed Potatoes Harvard Beets Coleslaw Royal Anne Cherries
31 Dried Fruit Compote, Scrambled Eggs • Cream of Mushroom Soup, Broiled Sweetbreads, Parsleyed Potatoes, Buttered Spinach, Relish Plate, Fudge Layer Cake • Split Pea Soup, Roast Veal, Gravy, Buttered Noodles, Mixed Vegetables, Spiced Crabapple Salad, Blueberry Crumb Pudding. Ready-to-eat or cooked cereals served on all breakfast menus.					

How Diamond Crystal seasoning packets end danger of cross-infection from dispensers

Old-type salt, pepper and sugar dispensers are often sources of infection. Require constant washing, sterilizing and servicing. Require storage space for both themselves and bulk seasonings.

Diamond Crystal packets are individual seasoning containers. They are disposable and sanitary. Need no servicing. And your patients appreciate their modern convenience.

Exclusive Diamond Crystal salt, pepper and sugar packets are hygienic. Save you money on labor and dispenser replacement

Old-fashioned seasoning dispensers can be an expensive problem to hospitals. They get dirty quickly. Shakers and bowls need constant cleaning. Re-filling. Sterilizing.

Considering the price of labor today, servicing several thousand shakers can really run up your operating costs.

Packets solve problem

Diamond Crystal seasoning packets are disposable. Hygienic. Eliminate dangers of cross-infection from dispensers.

Each packet contains a generous serving of either pure Diamond Crystal salt; spicy ground black pepper; or fine granulated sugar. When the patient finishes his meal, the packets are thrown away.

There is never the danger of broken glass dispensers when you serve packets.

Exclusive "shaker" action

Only Diamond Crystal packets let you *shake on* seasoning. Their sturdy fluted paper construction allows the same *method* of application as old-type dispensers—without the costly need of regular washing, filling and sterilizing. Your saving on dispenser servicing alone more than makes up for the slight additional cost of packets.

Exclusive "Shaker action" of Diamond Crystal packets allows controlled application of seasoning.

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See for yourself how Diamond Crystal packets can save you time and money. Just mail the coupon below. You will receive a free sample box of 100 Diamond Crystal salt, pepper and sugar packets for your own use by return mail.

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REFLECTIONS ON HOSPITAL LIGHTING

6. The Operating Theater and Recovery Room

HOWARD HAYNES and K. A. STALEY

IN THE operating theater, the use of advances in lighting design have perhaps the greatest justification. Many hospitals, however, have been less than prompt about redesigning operating room general lighting. (It seems to be the last part of the building anyone wishes to disturb.)

Continuing the series on hospital lighting. The authors are application engineers in General Electric's Nela Park lamp and lighting headquarters in East Cleveland. They have been gathering the material for the last three years. The MODERN HOSPITAL is presenting the articles serially as reference aids to the hospital architect, designer, consulting engineer, administrator or departmental executive who is planning new space or the relighting and redecorating of existing space.

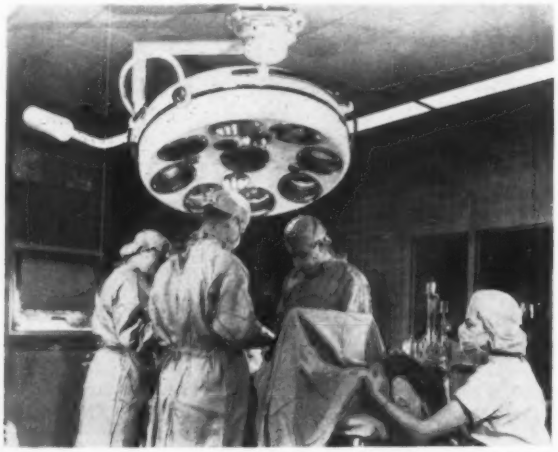
The finest lighting obviously is essential in a surgery, where so much depends upon instantaneous, accurate seeing. Because the surgeon may be looking deep into a cavity, he requires approximately 2000 footcandles or more of local lighting. For brain and other surgery, as high as 10,000 footcandles is in order, and relatively easily achieved. The light must come from several directions to decrease shadows from the surgeon's head, his hands, and the surgical instruments. Heat absorbing glass filters are necessary in surgical luminaires to reduce radiant heat and provide color correction so that veins and arteries will be easily distinguished and to facilitate seeing of other colors and tints that are of diagnostic importance in an operation.

LOCAL LIGHTING

The generally applied sources of local lighting are illustrated. The methods represent many years of development. The resulting beam control is of a high order of excellence. One system shown, which gives a high lighting level, utilizes a lens-plate pattern mounted in the ceiling of the room. The choice of system is generally based on the surgeon's experience.

All operating lights should be supplied by branch circuits independent of all other circuits. These circuits also should be connected to the emergency

In this system, designed for brain surgery and similar operations, surgical lights give maximum of 10,000 footcandles. Ceiling panels are fitted with cool white lamps, blending with light from color-corrected filament lamps.



Nine 40 watt silvered bowl lamps in this operating luminaire are focused on a spot 42 inches below the reflector-holder assembly. Color correcting, heat absorbing filters will absorb infrared radiation and whiten the light.

The sound-absorbing ceiling of Armstrong Travertone contributes to the distinctive atmosphere in the lobby of the Virginia Mason Clinic in Seattle, Washington. *Architect:* John Graham & Co. *Acoustical Contractor:* The Brower Co.

How to sound-condition your hospital and improve its appearance

Peace and quiet are wonderful medicines--one reason why Armstrong Travertone Ceilings were selected for this modern clinic. Highly efficient, Travertone absorbs up to 80% of the noise that strikes it, benefits patients and staff alike.

One look at the photograph above shows how the texture of Armstrong Travertone adds to the attractiveness of the room. Its handsome fissured surface reflects the ageless beauty of travertine marble and lends a feeling of elegance to any hospital interior.

Travertone is an incombustible mineral wool material that is completely fire safe. It will not ignite or support combustion. This feature provides the extra margin of safety required by many building codes.

Travertone is economical to maintain. It can be easily cleaned by an occasional once-over with a vacuum. If repainted, there is no loss of acoustical efficiency.

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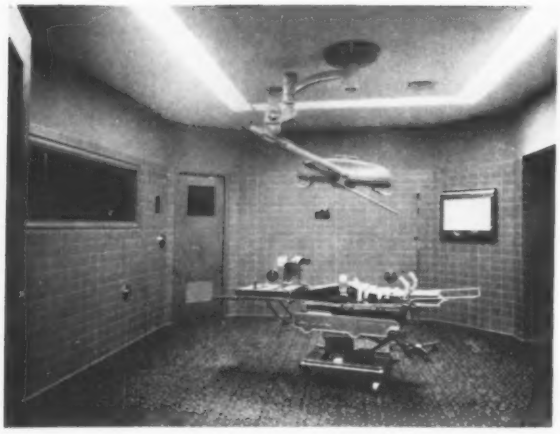
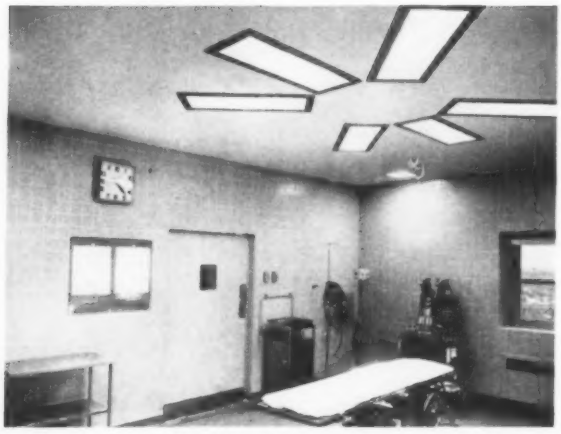


A continuous band of flush-mounted troffers provides the type of ceiling lighting illustrated here and adds greatly to the eye comfort of the operating surgeon and staff.



In this prismatic lens-plate lighting system, each triple-plate assembly contains three 150 watt filament lamps and matched reflectors, totaling 2700 watts in the system

Good local lighting for a surgical operation can be obtained from the system of plastic rod light bars shown here. The bar can be held close to or actually in an incision or cavity. About 1000 footcandles is provided.

Continuous fluorescent luminaires along both the walls make operating theater corridor lighting comfortable for patients and for hospital staff. For a wide corridor, 24 inch panels with two rows of lamps are recommended.

bus. An automatic throw-over switch should be provided to connect operating room lights directly to the emergency supply line, in case of failure of the main power supply. In the best systems, this is virtually instantaneous.

Where an extremely high level of approximately 10,000 footcandles is desired, as in brain operations, a pair of surgical luminaires is used together, as shown in the illustration. The lamps are controlled by a variable-voltage transformer. By turning a control knob, the voltage on the lamps can be increased to produce the high candlepower required. Some sacrifice is necessary in lamp life. In this connection, instead of replacing lamps in surgical and other luminaires one by one as they burn out, group replacement is recommended in surgeries at intervals of about ⅔ design (or expected) life. The method has many advantages.

The general lighting systems of large-area-low-brightness luminaires shown have special merits. The elements are flush with the ceiling, they have uniform brightness, and the surfaces are smooth and can easily be cleaned.

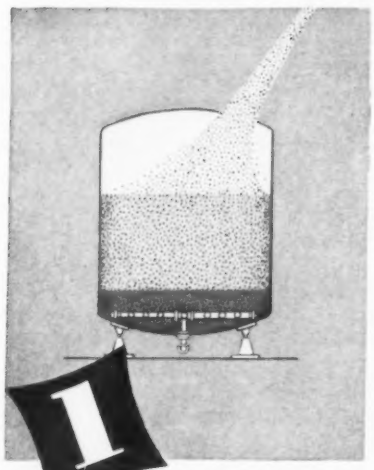
For superior seeing, a general lighting level of 100 to 200 footcandles is desirable. Today 50 to 100 footcandles is representative of good practice. Fluorescent lamps produce these levels with less radiant heat; this is a point of considerable concern in the operating theater. Cool white lamps are preferred because their light blends best with that of the color-corrected filament sources used in surgical luminaires.

Suspended luminaires, which illumine the ceiling "background," should be equipped with louvers and shields so that lamps are well hidden from view. Shielding of 45° both ways is preferred. Some louver materials used in flat panels, which give 60° shielding and may be preferred in some rooms, are now available. The purpose is to protect the eyes of both the surgeon and his assistants from glare when they look up from the immediate operating zone.

MINOR SURGERY

Eye, ear and throat, and some rectal, examinations and operations are best performed under illumination from devices which confine their light to a small spot. The two most widely used methods are: (1) a filament lamp on a stand (or held by an assistant), which is used with a head mirror, and (2) a small spotlight lamp fitted with a lens and reflector mounted on a headband. Lamps used with the head-mirror vary in construction. The one

Three Ways to Get MORE SOFT WATER



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By Refilling Your Water Softener With New High Capacity Elgin Zeolite you can get 3 to 10 times more soft water.

Think of it, from 3 to 10 times more soft water from your present water softener by simply refilling it with one of Elgin's new high capacity zeolites. Here is a dividend-paying investment you can't afford to pass up. In addition, regeneration will be required less frequently with savings in regeneration time and salt costs.

Replacement of lost or worn-out zeolite also will provide increased soft water output. All types of zeolite are available for immediate delivery.

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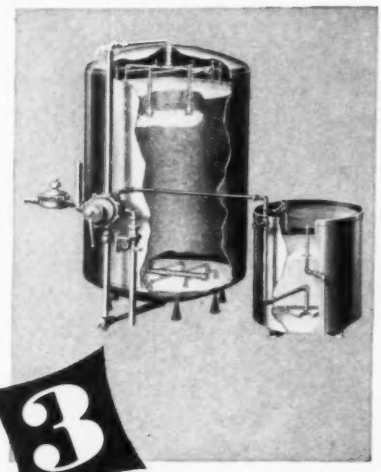

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By Installing A New Elgin Water Softener of "Double-Check" Design which gives up to 44% more soft water than softeners of conventional design.

Where new equipment is required, here is today's outstanding buy. Size for size, the Elgin Water Softener of "Double-Check" design delivers up to 44% more capacity than water softeners of conventional design. This big increase is due to the ingenious "Double-Check" manifold system of the Elgin which permits far more zeolite to be placed in the softener without zeolite loss. Get the facts about this amazing water softener before you buy.

. . . and some added Elgin Services for Hospitals . . .

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ELGIN DEIONIZERS produce mineral free water to replace distillation at a fraction of distillation cost.

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most widely used and recommended is a neck-silvered 100 watt spotlamp in a light inside a frosted bulb.

A third method, recently developed, employs solid plastic rods with the concentrated filament light source in a housing. In this device, the low voltage coiled filament lamp directs light into one end of the plastic rod, and the rays are transmitted by internal reflection and through flexible joints to the other end of the "light bar."

The light bar is about an inch in diameter and can be held close to or actually in a cavity or incision. The bar can be held in position or temporarily clamped in place. About 1000 footcandles of illumination is produced. The device can also be used in combination with other methods.

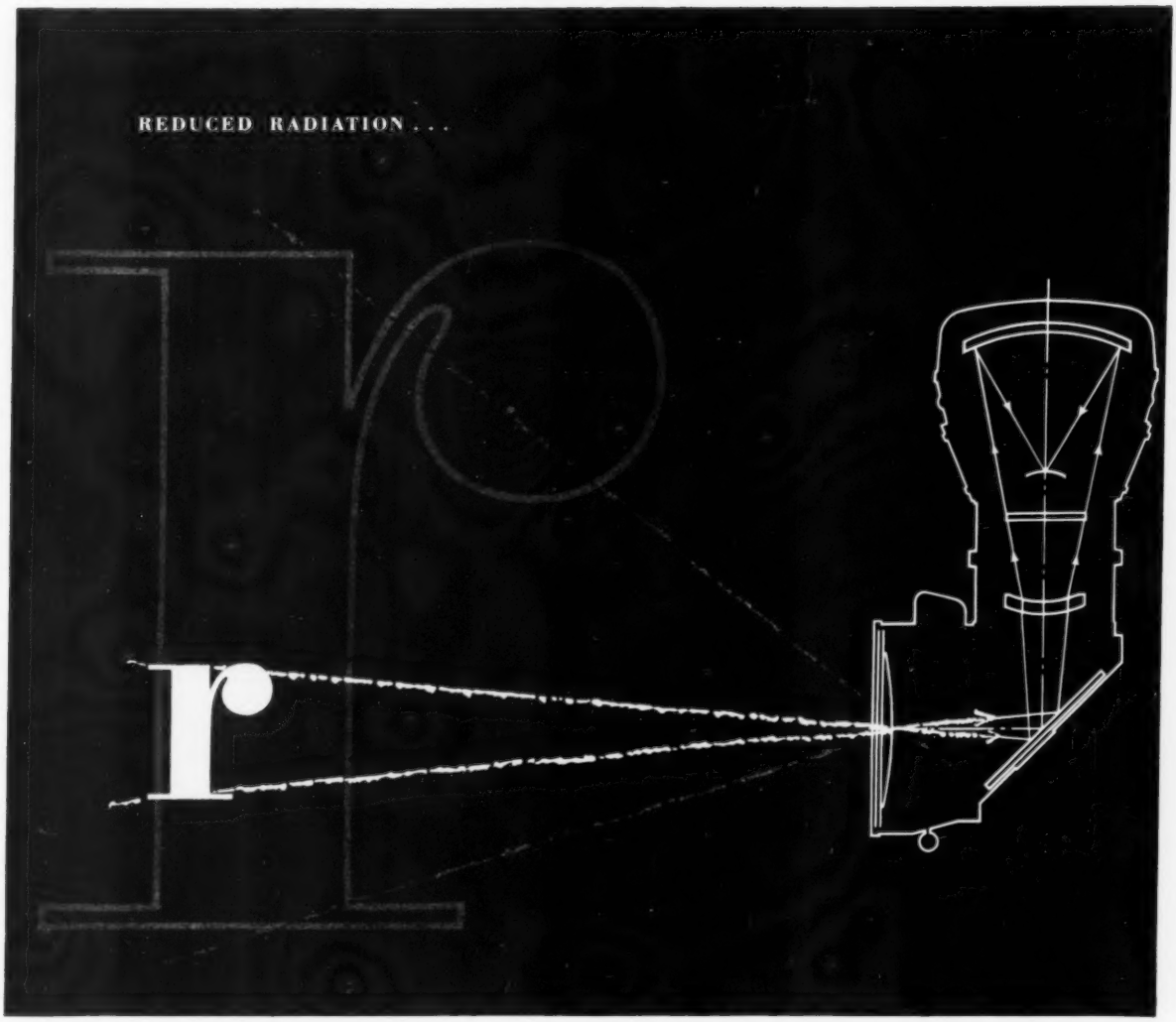
RECOVERY ROOMS

The advent of the recovery room for postoperative patients is a great surgical boon. It has saved many lives. More than half of the 200 bed hospitals and nearly all of those larger than this have them. Recovery room nurses have special training and are specially chosen. Checking blood pressure, pulse, respiration, and attending patients who vomit or exhibit other reflex actions are, in a recovery room, quick-seeing tasks. For expedient performance, they require more than the usual patient room or ward room lighting. Because the room is crowded with beds at times, the lighting should be nearly uniform over the entire floor area, not centered on one wall, or in the mid-section, as it might be designed in other rooms.

The time element in near-accident-after-operation prevention is more than usually pertinent. Watching bandages for drainage, looking for signs of skin color change, strained muscular activity indicating difficult breathing, all of these and other patient movements and indications are easier to see quickly if the lighting is of a high order.

Speed of seeing also is most important. The recovery room nurse must move fast. Within seconds she needs to find apparatus, make split-second decisions, summon aid if necessary. She needs to see across the room rapidly, without difficulty. A high level of illumination aids these operations.

Recovery rooms are also used for critically ill medical patients. Intensive therapy of various kinds is conducted as a result. Even outpatients in



Radiation exposure reduced 70-80% with concentric mirror photofluorography

The Fairchild-Odelca photofluorographic camera, with its Bouwers Concentric Mirror Optical System, offers a practical solution to the problem of radiation in X-ray examination. Because its speed is four times that available in present refractive lens cameras, patient exposure to X-ray is reduced by 70-80%.

Diagnostic quality negatives

At the same time, resolution is more than doubled—which insures sharp, crisp negatives of diagnostic quality. The resolution of this system exceeds that of the fluorescent screen. The camera's speed also stops much voluntary and involuntary motion, virtually eliminating retakes.

Economically speaking, the Fairchild-Odelca is exceptional, for the 4" x 4" size means low film cost and minimum storage space. Pre-focusing and pre-positioning make operation simplicity itself . . . and there are no heavy cassettes to handle. (Also available in 70 mm. roll-film models for mass chest survey, hospital admissions and serial radiography).

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need of temporary watching are sent to this room.

The specifications of lighting for recovery rooms should include a level of illumination of 50 to 100 footcandles. The color of light and the quality of the lighting should be the very best.

If open types of ceiling luminaires are chosen, it is recommended that fluorescent lamps in the low-brightness class be used. There are three lamps (cool white is preferred, usually) which are in this category: (1) a 48 inch lamp at 200 ma (current); (2) a 60 inch, 40 watt instant start lamp, and (3) a 96 inch lamp, again at 200 ma current. The problem of ensuring quiet operation of fluorescent ballasts has been mentioned. Ballasts with sound ratings A, B or C should be specified, or other means of quieting, such as remote operation of the ballasts.

CORRIDORS

The corridors in an operating theater are not strictly corridors in the accepted sense, as their space is much more vital to the staff and the patients in them. Patients awaiting transfer to the recovery room, those who are ready to go to surgery, others who are on their way to other floors or remote sections of the hospital, all are occupants of the corridor for part of the time.

No reduction in vigilance is expected from the staff in this area; patients' needs may be momentarily just as acute as they may be in the recovery room. There is, therefore, no excuse for "more economical" or "standard" corridor lighting in an operating theater. It should be top quality.

The corridor space may or may not have a lower ceiling than adjoining rooms. In either case, the lighting almost universally in vogue is the so-called flush-type troffer lighting with its smooth surfaces for easy cleaning.

The small cross section of the corridor makes it more difficult to light. The wall area is relatively large in comparison to the floor area. Walls absorb much of the light, even though they are correctly of 40 to 60 per cent reflectance. Hence, about twice the usual lamp watts per square foot are necessary to obtain really excellent results. The use of large-area, low-brightness luminaires is recommended, since patients must look upward more or less directly at them for a good part of the time. In their weakened condition, patients should not have to bear the extra strain of looking at a glaring light. Corridors with two lines of continuous luminaires along the walls are the most visually comfortable for all concerned.

In the corridors and adjacent rooms, the surfaces should, in general, be light in tone, though not necessarily white. Not a little of the desirable seeing comfort in any interior may be due to a good choice of color for the floor covering. There is no housekeeping need for floors to be dark. A light floor (30 per cent) has greater ability to bounce light up toward the ceiling, relieving the contrasts which a luminaire or light panel may make with its immediate surroundings. Light from the floor may be the only means of relieving this condition. Again, good design keeps light in circulation; the hospital administration is interested in getting good value for its lighting dollar, as well as any other dollar. Anything the designer can do to extend the usefulness of the lumens bought for the lighting dollar helps the sight of all. In a hospital, seeing is the most important sense.

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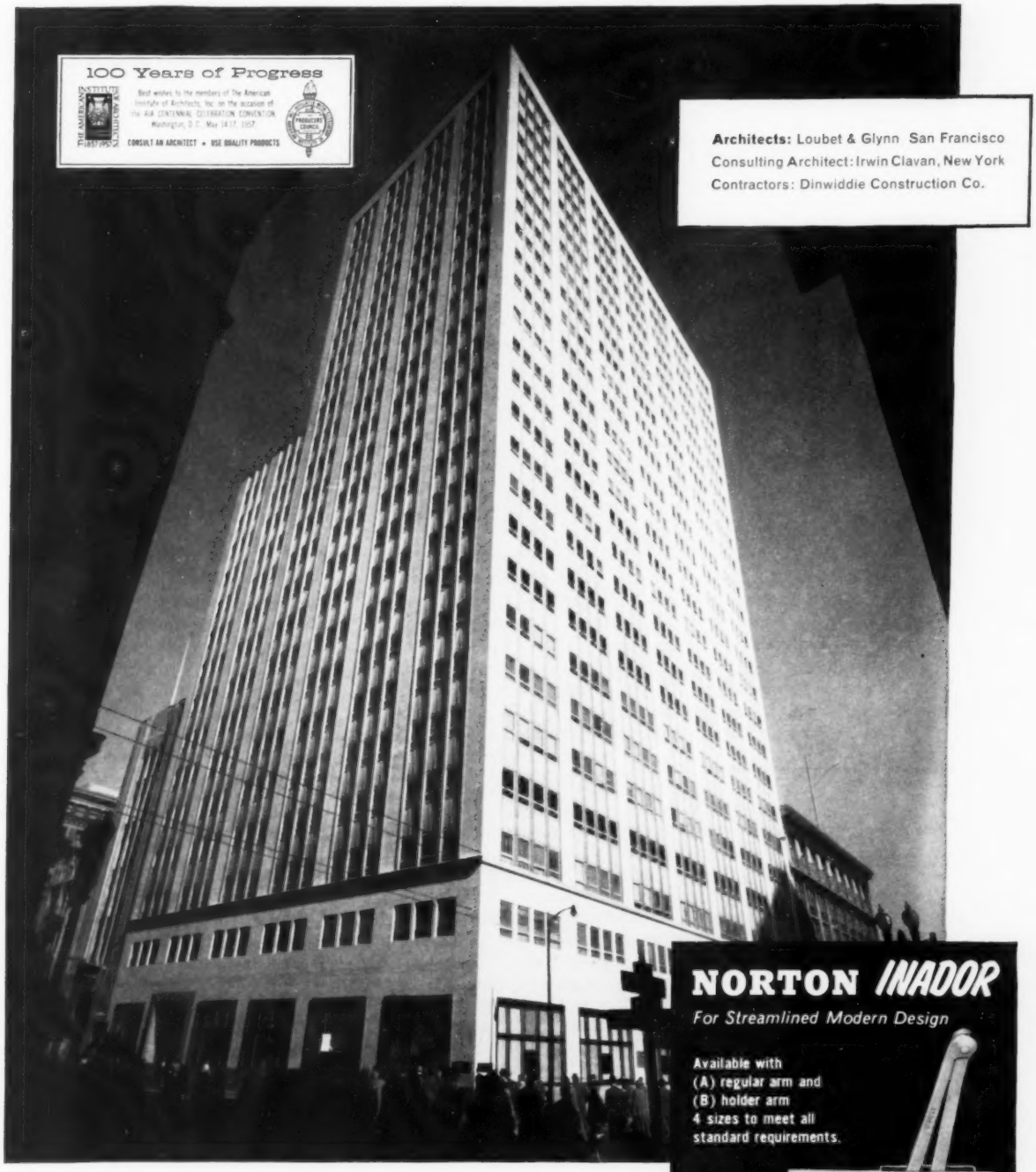

1800 DOORS EQUIPPED WITH NORTON CLOSERS IN NEW EQUITABLE LIFE BUILDING...SAN FRANCISCO

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A Training Program for Housekeepers

5. Building the Powers of Observation

BARBARA D. MILLS

THE next portion of your training will be based on the "3 W's": Walking—Watching—Writing. I was rather hesitant to use the "3 R's" for fear it would be translated to Resting—Relaxing—Reposing! During this period you will be given an opportunity to participate in programs, undertake projects on your own, and develop procedures through motion and time studies and work simplification. The outline you have covering this phase of your training is merely a framework for what is expected of you during this time—not what is to *come*. This business is rather like love: You must see and experience it before you truly realize what it is all about.

The objective of the outline, as you can see, is merely to point out and assist you as an individual in functioning correctly. Know the limits of your authority; learn to move as effortlessly as possible; be *restrained;* don't fling yourself at people. However, by the same token, you are not striving for a "lounge and cafeteria diploma"!

I won't pretend you are in for an easy trip. There will be days when you will be reduced to tears and will hope that in your next incarnation you will be *any two things* other than what you are striving to be. (When that day comes, take a walk and find yourself and that stillness within.) But during these months you do have an opportunity of opening doors that will take you from the "vestibule" training period to the exciting experience of face-to-face contacts. Your thinking will be flexed and trimmed; you will learn to think together as a team. (*Cont. opposite page* 129)

Mrs. Mills is director of housekeeping services, St. Luke's Hospital, Chicago.

W W W — POWER OF OBSERVATION

All employes training for any supervisory position in the housekeeping department devote two to three months to Walking—Watching—Writing (3 W's). From it you learn that what really teaches man is not so much experience as observation.

Your program during this period is to *observe* and *note* daily routine rounds which, in part, include:

1. What the supervisor does.
2. How the supervisor does it.
3. To whom she speaks: (a) lines of communication; (b) power of communication.
4. Manner and method of establishing or correcting a procedure.
5. Meeting the emergency.

Your *suggestions* and *advice* will be appreciated but write them as the closing paragraph after your written outline of the observation and when I check your notebooks they will receive consideration.

As you are a student your evaluation of personnel performance is not necessary. Handling of employes and their problems will be part of your training but *after* you are capable of outlining routine procedures from observation.

Questions regarding what you observe should be asked after the supervisor has finished the inspection, discussion or procedure. If the supervisor is discussing a problem or giving instructions to personnel, further discussion should be held until employes have left.

Always remember that what you write must be so simple that an individual unaccustomed to our procedures would be able to follow.

Notes you take while walking can be put down in the way that is easiest for you but the translation should be done in a step-by-step outline fashion. So that your observations will become distinctly outlined in your mind, discussions on the matter should be had during your traveling time.

Today take each thing in your stride and tomorrow will take care of itself. You will always be given the complete picture but only when it fits into the pattern of our program for you.—B.D.M.

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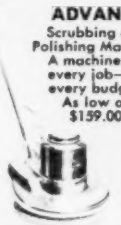

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LAUNDERING OF LINGERIE—WRONG WAY

Purpose: Clean lingerie for next day's wear

Equipment: Soap flakes, water and washbowl

General Information: Lingerie and stockings

ESSENTIAL STEPS	SPECIFIC INFORMATION
1. Fill washbowl ¾ full lukewarm water. Add one tablespoon soap flakes	1. With hands swish through water to dissolve soap flakes
2. Wash slip first. With hands squeeze water and suds through slip	2. May have to rub top of garment between hands
3. Rinse in same order as washing, using lukewarm water, dipping garment up and down in water	
4. Hang up to dry	4. Will drip. Be careful where you hang garments

LAUNDERING OF LINGERIE—RIGHT WAY

Purpose: Clean lingerie for next day's wear

Equipment: Soiled lingerie, soap flakes, water and washbowl

General Information: Use bowl in bathroom; soap flakes on floor under bowl; will drip, be careful where you hang garments

ESSENTIAL STEPS	SPECIFIC INFORMATION
1. Fill basin or prepare water	1. (a) Fill washbowl ¾ full lukewarm water (b) 1 tablespoon soap flakes in water (c) With hands swish through water to dissolve flakes
2. Wash	2. (a) Wash slip first, then other garments and stockings (b) With hands squeeze water and suds through garments (c) Put most soiled part, such as feet of stockings, between hands (d) Squeeze water out of garments Do not wring
3. Rinse	3. (a) Lukewarm water (b) Same order as washing (c) Dip garments up and down in water (d) Squeeze water out of garments Do not wring
4. Hang up to dry	

These two outlines show how easy it is to omit essential points in the step-by-step teaching process.

You have spent many weeks on the development of creative thinking, preplanning and preapproach, which at this point should be constantly made manifest in your thinking and reports. To help you to keep your outlines uniform, I should like you to become acquainted with a form of outline which, if used correctly, will eliminate *writing* yourself to death. This form or outline is known as a format. The principal reason for the format is to give you a standard form on which to record the *essential information* gathered from your observations throughout the 3 W period.

SAY WHAT YOU MEAN

In housekeeping phraseology, exactness is of *paramount* importance. "Go" is less specific than run, walk or ride.

The first requirement for good expression, then, is exactness; the second principle of good expression is simplicity.

Confusion. Let us be good listeners. We are barriers against ourselves because we cannot hear any voice of serenity, which is the only antidote I know about for this word or state of being. I mention this for you will also find that you must be quite exact in your thinking as you outline each step of any job you have to do or teach someone else to do. To clarify this procedure, let's take a simple and routine operation such as "laundering of lingerie." I am sure you all have this little task to do, either nightly or once a week, and know just how to go about it. But do you know how to make clear to another person just what procedure to follow?

The "wrong way" and "right way" charts show how easy it is to omit many steps—just because we take them for granted.

As you can see, it also takes practice to break down "job skills" and/or required knowledge into simple steps for application at the "firing line" group (service personnel). As you now realize, the several parts make the whole which becomes the foundation upon which procedures are built.

Remember it takes a great deal of study to grow. Write your reports up daily—translate them into an *actual* experience so that in the future you can refer to your book to answer your own needs. Learn to treat each disappointment as material for a step farther toward success and, for heaven's sake, don't get panicky at your failures and do nothing about them. Your books will be picked up periodically for general checking. Grades are not given until time of your first examinations.

MAKE THE MOST OF OPPORTUNITY

I should like to make one more comment before you take flight. Today we are in the habit of *taking so much for granted* and, if at no other time you are grateful to St. Luke's Hospital for this training, you should be for this one phase of it. This business of observation—the opportunity to observe—is something to *treasure* regardless of what lies ahead for you.

Good luck on your new venture. Success is no accident. One must work, strive and hope, and then work some more.

This is the fifth lecture in the series given by Mrs. Mills to her administrative housekeeping trainees. In it she reviews the written part of the program and prepares her students for the period devoted to "walking, watching and writing." In the next lecture Mrs. Mills will cover problems encountered by the housekeeping trainees when they are "out on the floor."

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- Quiet V-belt, roller chain drive
- Fewer parts, easy to get at for easier maintenance

THE UNLOADING EXTRACTOR

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- Smooth balancing of loads
- Stainless steel construction
- Automatic timing of cycle
- Rugged, simple, easy to maintain

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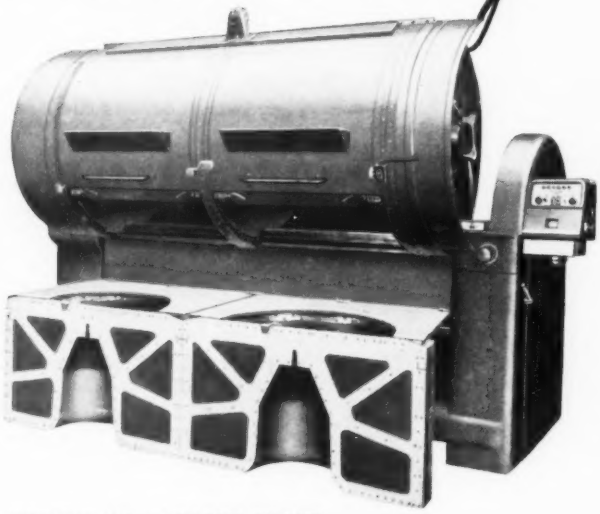

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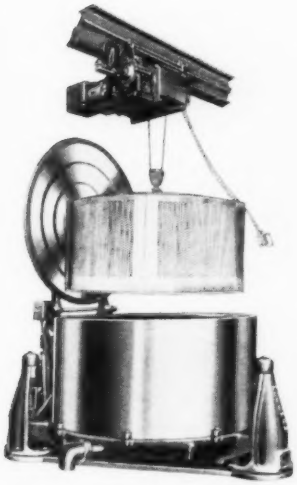

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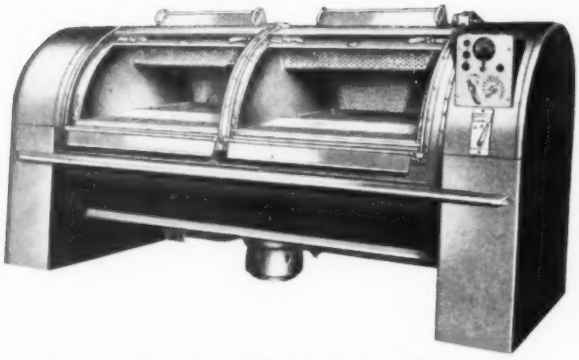

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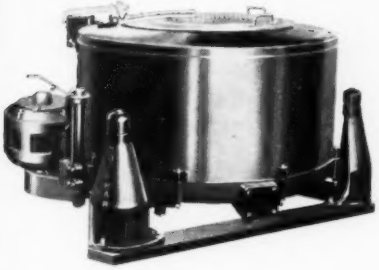

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Hospital Chaplaincy

(*Continued From Page 54*)

my name for him. Over and over again he told me that if God would only let him walk again, he would serve God with all the rest of his life. It became my assignment to help him see for himself that God was already using him there in that ward. If I had told him this outright, it might have meant to him that his chance to walk again was nil, and so have cost him his courage. So we talked of mountains, someone having sent me a view of the Grand Teton, and then of trees, the Emperor reciting Joyce Kilmer's poem, and of rivers, with the Emperor rumbling a line of "Old Man River."

Then he persuaded the young Italian to walk, and then to improve daily until the boy went home to a fairly active life. At this the Emperor was radiant, but he was modest about it, too. When he said once more that if God would let him walk, he would serve him all the rest of his life, I broke a rule and asked him if he didn't think God was interested in what he had done for the Italian boy. He hadn't done much, he said. But a few days later he told me that he had prayed early that morning for the other men in the ward, and that perhaps by being there he could help those who were not so badly off as he. "When they get impatient," he said, "I tell them they have to wait for God. They don't know I get impatient, too."

I remember polio patients with whom I worked in successive summers in Boston and in Ann Arbor, Mich., especially young fathers and mothers tortured with anxiety for their families, and patients of college and high school age, old enough to understand the one chance in four they had of dying or being crippled for life. One night in Boston there were not enough respirators, so the patients had to be put in and out of respirators in turn. I never saw such courage even in my experience with a major war.

That night a doctor came down the line, stopped by a teen-age girl whose head alone emerged from a respirator, and said to her, "Barbara, I think you could breathe for me, for a little bit, if you tried hard." When the girl's eyes looked back at him unafraid, he had the motor stopped and the window thrown open. Then he said, "Try, Barbara . . . try harder. Try harder still . . . with all you've got. . . . There it's coming . . . don't quit now . . . keep on. Splendid. . . . Now once more, just once. . . . Don't go back on me. Go on! . . . If you finish this one, I'll go home too happy to sleep. . . . Finish it now. There you are. Good girl. All right, shut the window, and turn on the motor." Meantime, the others of us around that respirator were breathing with the girl as she breathed, while we prayed. More than once that September I wondered at midnight what was the matter with me, and remembered that I had not eaten for 12 hours.

There was Summer Freshman (his real name), a crack athlete just out of high school, with two ambitions—to play on the football team of a near-by university, and to see that his Jewish mother never was in want as long as she lived. Polio hit him harder than it hit the other half dozen young men of his age in the same ward, but he pretended that it hadn't; and the others, knowing that he had a harder row to hoe, drew courage from his fine example. When the doctors told him that he could never compete as an athlete, he merely nodded. Some well-to-do men of his religion rented an athletic field for a Sunday afternoon exhibition by Boston's best high school athletes, and the gate receipts gave Summer and his mother enough to set them up in business, and to allow Summer to have his years at the university.

FRESHMEN ADOPT SUMMER

When, from the first football game played that fall by the team on which Summer had hoped someday to play, there came to the hospital a senior center with an injured hand, and he heard Summer's story and learned that officials at the university were too busy to take up a suggestion that the first year class might be willing to adopt Summer as an honorary member, the senior said, "When I get back to school, I am going to see what can be done about that." One of the last things I remember from my last week in Boston was a call from a dean at that school to say that Summer was being adopted by the freshman class.

I remember a woman of middle age in a mental hospital in Washington, D.C., who surprised the staff on duty in her ward by saying she was ready to go home. She was examined and pronounced cured. She explained that the day before a chaplain-intern, in a brief talk before celebrating post-Easter Communion in her ward, had said that Jesus' words, "My God, my God, why hast thou forsaken me?" were one of the most surprising things in the Bible, since He who spoke them had been so certain of His Father's love, and one of the most terrible, since He who spoke them had been so merciful and yet so badly served, and one of the most reassuring, since they made it clear that Jesus "knew from experience all that this life can mean." The psychiatrists who sent this information to the chaplains' office added that the woman had said, "I see now that I have been wrong to be angry at God."

I remember a young athletic coach from Kansas who was in such pain in the Denver hospital that he begged me to help him end his life. I told him, of course, that I could not, but said I could not blame him for wanting to end it, and could not think that God would condemn him for wanting to end it when he was drowning in a sea of pain. But I said I hoped he would not, for the sake of his wife. He agreed that she was splendid, and I said a prayer for him, in which I pleaded Paul's promise that God will not allow us to be tried above our ability to endure, but will with the trial make also the way of escape, that we may be able to endure it. The next morning he told a nurse that God had said to him in a dream that he would not let him suffer too long, and in a few more days God kept the promise.

Over and over again in my years as a hospital chaplain I remembered the saying that we give the worst account of ourselves when things are easy, and the best when we fight against odds. With few exceptions the patients in real trouble stood up to it so that I have felt, not that they owed me anything, but that I owed them much for the courage, and often the faith, with which I have seen them face suffering or death or bereavement. Long ago I read a few lines in French, the latter part of which has been borne out by these hospital years: "Passing griefs cry aloud against heaven, but great griefs do not cry aloud against heaven; they keep listening."

I have found these words of David Grayson's also borne out by hospital experience, that "as we look backward, those times in our lives which glow brightest, seem most worth while, are by no means those in which we have been happiest or most successful, but rather those in which, though painful or even sorrowful, we have been most necessary, most desired."

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Employe Health Programs

(*Continued From Page* 70)

cian for specific prescribed tests accepted by your health service?" Thirty-one hospitals replied; 23 said "yes"; four said "no"; two said "sometimes," and two said only with approval by the employe health physician.

Part (b) asked, "Will the results of these tests be forwarded to the personal physician?" Of the 27 who replied positively to part (a) of the question, 25 will forward results to the employe's personal physician; one states that a special request to the health service is required, and one does not forward the results.

Part (c) asked, "What is your practice regarding charges for this service?" Twenty hospitals stated that there is no charge, three hospitals charge half the regular hospital rate for tests performed; two make no charge to permanent employes; one charges only for "costly" tests (which were not specified); one provides the tests at cost, and one charges clinic rates.

Question 18 asked for a statement of practice regarding charges to employes for medications prescribed by the health service physician, by members of the attending staff, and by a nonattending private physician. As might have been anticipated, there was an unusually wide range of replies which we attempted—not too successfully — to summarize. Of the 30 replies to the first part of the question, 12 hospitals stated they make no charge for prescriptions from their health physician; six provide drugs at cost; three stated they have a "discount" arrangement; two hospitals reported that special consideration is given according to the employe's salary.

One hospital, each, gave the following arrangements: Employe must be an outpatient to get free medication; the employe is charged at patient rates; the employe is charged half the cost of the drugs; the employe is charged half the hospital rate; the employe is charged at clinic rates; the employe is charged cost plus a percentage, and "we do not supply."

Prescriptions from a member of the attending staff are handled as follows: Seven provide drugs at cost; six make no charge; three offer "discounts"; two charge clinic rates; two make special arrangements; two do not supply drugs at all on this basis; one hospital provides drugs at half the hospital rates; another provides them at half the cost; another "charges" (without specifying the amount), and another charges on a cost-plus percentage basis. There were 26 replies to this part of the question.

Prescriptions from the nonattending private physicians are charged at cost in eight hospitals, and are not supplied in four. There is no charge to employes in three institutions; in two hospitals, clinic rates are charged; in two others, special arrangements are made according to salary level; in two, a "discount" is arranged, and in two hospitals, employes pay the full patient rates. One hospital charges staff half the hospital rate; another charges half the cost; one hospital "charges" (but doesn't specify the amount), and one charges cost-plus-percentage.

Question 20, relating to special diet prescriptions for employes, also drew a variety of responses—as well as interpretations of the question. Thirty hospitals replied, 10 of which stated that special diets may be accepted with a minimum of processing or review; seven hospitals do not accept these special diet prescriptions because, in almost all cases, they have pay cafeterias; six hospitals require medical

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approval—that is, an official prescription; three hospitals state that their health physician must approve the request, and one hospital accepts only prescriptions for particular kinds of diets, such as salt-free.

We did not attempt to tabulate *Question 21* (a) and (b), which related to the health service's referrals of employes to special clinics, and their responsibility for follow-up of such referrals. In most cases, however, referrals are made through the health service to special clinics on the recommendation of the health physician. In a number of cases, referral to any clinic depends upon the salary level of the employe. In almost all cases, the health service follows up and records the results of these referrals; but in several instances, the clinic itself is responsible.

Question 22 referred to charges to employes for diagnostic tests and clinic visits recommended by the health service. Twenty-four hospitals provide both tests and clinic visits free; three charge at a discount; four provide tests free but evaluate for clinic charges; one provides tests free but has a routine charge for clinic visits, and one evaluates for both clinic visits and diagnostic tests on an individual basis.

Question 23 (a) asked if the health physician admitted employes as inpatients. Twenty-four hospitals answered "yes" and nine answered "no." The nine answering "no" replied to part (b) of the question — which asked who does admit employes if not the health physician—as follows: In seven hospitals, the private or attending physician admits; in one hospital, employes are not admitted (this is a TB hospital), and in one hospital, the personnel office and the admitting office admit employes.

Only seven hospitals answered *Question 24,* which asked for any special provisions in the health program limiting services, inpatient care, and so on, during a probationary period. Three of these seven offer services and care free after six months' employment, one after one year of employment. One hospital provides a discount on services after six months on the staff; one hospital only provides ward service after an unspecified period of probation, and one makes its arrangements on an individual basis.

HOSPITALS COMMENT ON PROGRAM

Question 27 provided space for comments, a few of which are quoted here:

"Employe health service is to serve department heads by providing them with information about health problems connected with new or prospective employes."

"We gave a great deal of study to the practicability of a formal health service and abandoned it. It seems to us that this is a duplication of functions already existing in a hospital, and that preexisting facilities can be modified to include health service functions. Railroad employes ride regular trains. The management does not set up specials for them."

And from the other side of the fence, from another hospital: "At present our health service facilities are totally inadequate as to record keeping, work space, and physician's time devoted to employe service. Administration is disinterested and I can't sell additional budget." And another: "The hospital's policy is that employes are 'encouraged to seek medical attention in our clinics and hospital, and should be informed that our facilities are available to them at all times.' "

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A.M.A. Delegates Adopt New Principles of Ethics at New York Convention

(*Continued From Page 50*)

tion, Catholic Hospital Association, and American Protestant Hospital Association, it was stipulated.

In another action approved by the House of Delegates, the reference committee on medical education and hospitals turned down a recommendation of the Council on Medical Education and Hospitals that its name be changed to simply the "Council on Medical Education."

Since the Joint Commission on Accreditation of Hospitals had taken over the accreditation activities of the Council's field staff and the registration or listing of hospitals had been turned over to the American Hospital Association, the Council said in its report to the House, its name "is a misnomer and should be changed in conformance to its true functions."

In the reference committee discussion, Dr. John W. Cline of San Francisco, a member of the Council, said that one reason the change was requested was to avoid confusion about the functioning of the Council in relation to the Joint Commission. Many physicians were still directing inquiries to the Council that should properly go to the Council that should properly go to the Commission, he reported, and it was felt that the change in name would help clarify the functions of the two groups.

Speaking for the accreditation commission, Dr. Kenneth B. Babcock, director, said he felt the change would be a mistake and would leave the impression that the A.M.A. was divorcing itself from hospitals. "If this change is made," Dr. Babcock said, "there will be no avenue of approach to the A.M.A. for hospitals and hospital problems."

NAME REMAINS UNCHANGED

Acknowledging that the words "and hospitals" in the Council's title might be nothing more than "window dressing and public relations," Dr. Herman G. Weiskotten of New York, who retired this year as Council chairman, expressed the view that this alone would be reason enough to retain the present name. Eventually, the reference committee recommended that the name should remain unchanged "because of the graduate education programs which are conducted almost entirely in hospitals and also since the hospital plays an intimate rôle in all phases of medical education."

Considering several resolutions condemning the United Mine Workers of America Welfare and Retirement Fund for restricting free choice of physician and hospital for Fund beneficiaries, another reference committee heard Fund Director Warren F. Draper deliver a stinging rebuke to some members of the medical profession for their performance in Fund areas.

"While the majority of the 6800 physicians who are receiving upward of $17 million a year in payment by the Fund have rendered high grade, conscientious service under conditions of mutual confidence and satisfaction," Dr. Draper declared, "there are those who, for lack of qualification for the work they have undertaken, or for other reasons, have not. In consequence, both the beneficiaries and the finances of the Fund have suffered greatly from unnecessary surgery, unnecessary hospital admissions, excessive length of stay of hospitalized patients, and services of inferior quality often resulting in duplication of treatment and costs at a later date."

(*Continued on Page 140*)

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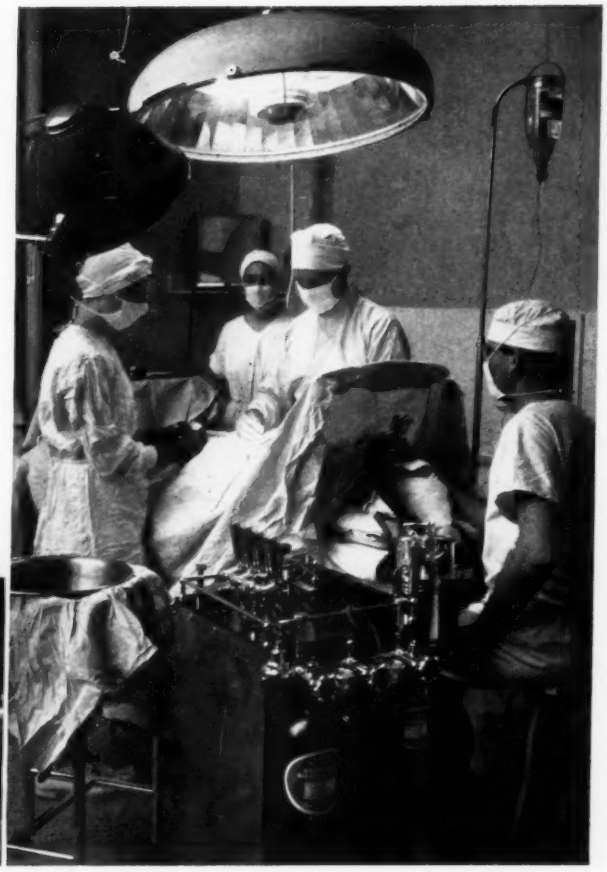

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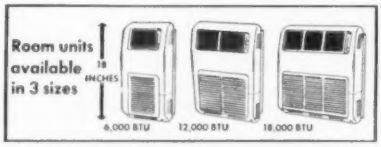

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(*Continued From Page* 138)

Presentation of these facts to state and county medical societies had resulted in little if any improvement, Dr. Draper said. "In our experience, county medical societies and hospital staffs are too often reluctant to supervise their colleagues and effect the drastic changes in local practices and patterns of care that should be made," he added in a prepared statement made at the reference committee hearings on the U.M.W.A. "free choice" resolutions.

To diminish these problems for its beneficiaries, the Fund ruled that patients would be admitted to hospitals only following consultation with specialists, Dr. Draper explained. "The resulting reductions in the rate of surgical operations and hospital admissions were in some instances from 30 to 50 per cent, and the advantages to the patient of specialist consultation were found to be considerable," he reported.

However, medical societies bitterly resisted the consultation requirement, and the Medical Society of the State of Pennsylvania abruptly terminated an agreement with the Fund, which nevertheless continued "to utilize as far as practical the services of surgeons whose qualifications are established" by certification by specialty boards or membership in the American College of Surgeons, Dr. Draper related.

"This effort to insure a high quality of medical care for its beneficiaries and reduce the cost of unnecessary hospitalization and surgery is again encountering the violent opposition of certain segments of organized medicine, with the assertion that the Fund is thereby lowering the quality of medical care to the patient, is discriminating unfairly and interfering with the free choice of physician," Dr. Draper reported. Termination of the agreement with the Medical Society of Pennsylvania was followed, he said, by "a rash of vituperative, unsubstantiated and misleading statements and articles in the publications of certain medical organizations, in the public press and elsewhere, together with resolutions and actions by certain county medical societies which are questionable as to their ethics and legality."

So that no one could mistake his meaning, Dr. Draper made his intentions perfectly clear: "Petty persecutions such as those by certain county medical societies which endeavor to prevent the Fund from providing medical care for its beneficiaries by denying membership in the county medical society to physicians who do so will be settled by legal means if other measures fail," he said. "The program cannot stop; it must go on."

DELEGATES APPROVE RESOLUTIONS

By way of reply, the reference committee and the House of Delegates approved all the resolutions condemning the U.M.W.A. in principle and adopted a statement of "Guides to Relationships Between State and County Medical Societies and the United Mine Workers of America Welfare and Retirement Fund." This stipulates that Fund beneficiaries "should be free to select their own physicians from among those willing and able to render such service," and adds that "every physician duly licensed by the state to practice medicine and surgery should be assumed at the outset to be competent in the field in which he claims to be, unless considered otherwise by his peers."

Striking back at alleged attempts by the Fund to influence hospital staff appointment, the "Guides" provide that "free choice of physician and hospital by the patient should be preserved,"

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This hygienic atmosphere helps safeguard both patients and personnel against acquiring infections while they're *within* the hospital. The possibility of nosocomial infections can definitely be reduced in the nursery, surgery, delivery and patient rooms.

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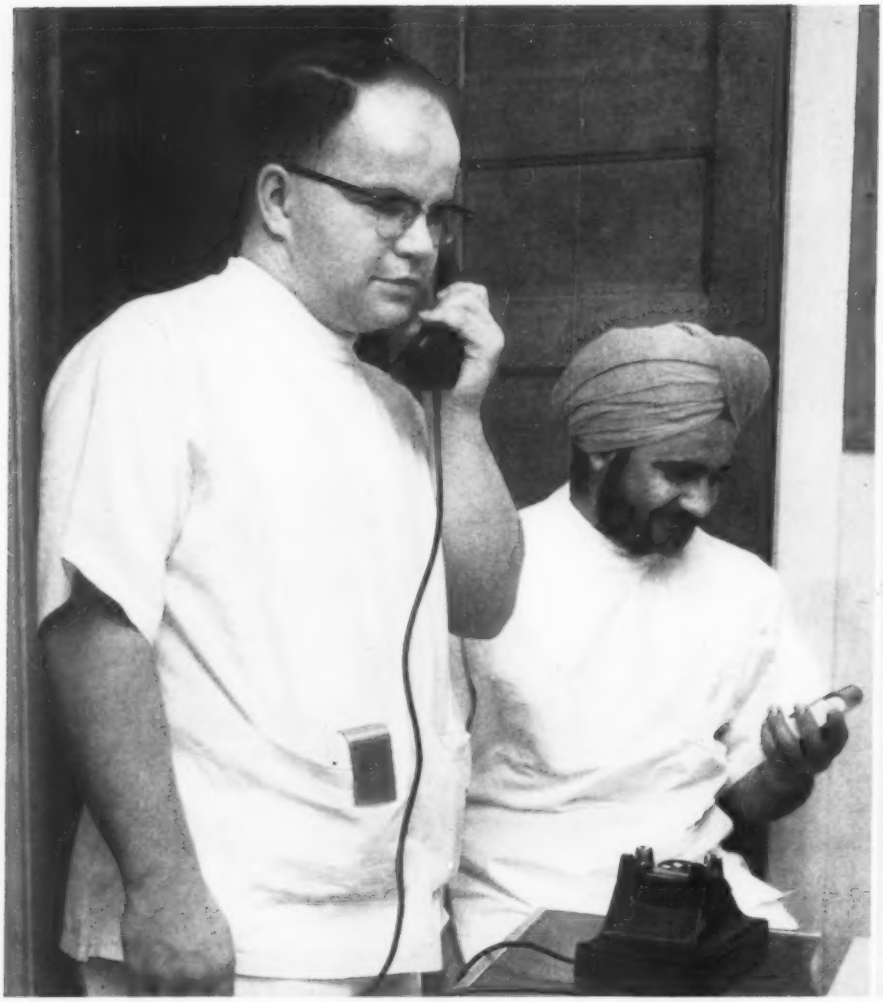
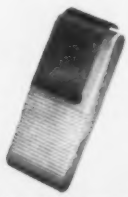


Dr. John Ring (left) assistant, and Dr. Sarab Bhatia, chief resident in surgery, figured in dramatic test of PAGEMASTER selective radio paging system shortly after it was installed in Ellis Hospital, Schenectady, N. Y.

A small, compact transmitter may be installed quickly and economically anywhere on your premises, with easy access to antenna location.

Encoder, about the size of an adding machine, is placed next to telephone switchboard. Anyone can learn to use it with just 5 minutes' practice.



Transistorized pocket-size receiver weighs only 7 ounces. Audible signal continues until paged party responds. Battery life is hundreds of hours.

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With a PAGEMASTER receiver *in his pocket,* Dr. Bhatia heard the pleasant, but clearly audible tone signal which told him he was wanted. He picked up the nearest telephone and reported. Within a few minutes he was in the emergency room, ready and waiting as the patient was wheeled in for treatment.

The man needed immediate surgery. Dr. John Ring, assistant resident in surgery, was instantly contacted via PAGEMASTER. The operation was performed in time. *The minutes the operator saved in reaching the surgeons helped save the patient's life.*

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and "the qualifications of physicians to be on the hospital staff and membership on the hospital staff are to be determined solely by local staff and local governing boards of hospitals."

In other actions, the A.M.A. House of Delegates:

1. Indicated that the effort of the Council on Medical Education and Hospitals to restrict straight internships would be modified, by approving a Council report stating that "straight internships of superior educational content are justified in the fields of medicine, surgery, pediatrics and pathology because of their comprehensive scope," and a further resolution adding that the Council would "consider applications for straight internships in obstetrics and gynecology on the basis of educational merit," the same as in the other specialties.

2. Disapproved a resolution seeking "local autonomy" for hospital staff meeting attendance requirements under the Joint Commission on Accreditation of Hospitals, when Commission Director Kenneth B. Babcock explained that staff executive committees had authority under the present standard to excuse members from attendance for "just cause," such as illness, emergencies, and absence from home for attendance at medical meetings.

3. Referred to the A.M.A. law department a California resolution aimed at protecting medical staff minutes and records of staff committee activities, which a California delegate said had been used against staff members by district hospital boards.

4. Rejected another California resolution proposing that hospital accreditation inspections be conducted by voluntary specialist teams; the resolution warned that the medical profession "must meet the responsibilities of hospital standards or surrender them first to hospital administrators and thence to other lay organizations."

5. Disapproved a resolution presented by the Hawaii Medical Association which asserted that hospitals requiring medical society membership for staff appointments are guilty of "closed shop or union shop" restrictions and sought to eliminate such restrictions. The reference committee said, "It would be inappropriate for the House of Delegates to adopt any position which would discourage membership in medical societies."

6. Instructed A.M.A. representatives on the Joint Blood Council to "take immediate action to have the Council designated as the contracting agency for blood procurement with all governmental agencies."

7. Asked a joint committee of the Board of Trustees and Council on Medical Education and Hospitals to study the desirability of licensure for practical nurses, medical technologists, x-ray technicians, physical therapists and other ancillary medical personnel.

8. Carefully changed the word "welfare" to "well-being" wherever it occurred in a long report on occupational health programs, "to emphasize the fact that the programs are primarily of a health and not of a social nature."

9. Endorsed the recommendation of the law department that the Board of Trustees should consider the advisability of entering into discussions with representatives of the American Hospital Association with the objective of formulating and implementing an effective in-hospital safety and accident prevention program, because more than two out of three of the incidents resulting in professional liability claims occur in hospitals.

10. Heard a report that, under a new regulation, the Veterans Administration would seek to tighten its methods of excluding care for compensation cases, but acknowledged that "the only definitive way to terminate the undesirable practices . . . would be by amending the law so that there can be no doubt as to its purposes and intent."

WANT MEDICARE MODIFIED

11. Urged the Board of Trustees to request the Secretary of Defense to "modify the Medicare program regulations and directives so that the program can be operated on an indemnity program where desired by individual states."

12. Approved a resolution condemning Medicare payments to hospital residents as "not in keeping with traditional patterns of medical practice throughout the United States."

13. Recommended a strongly stepped-up information program for physicians explaining the reasons for the A.M.A.'s opposition to Social Security coverage for physicians, and rejected a resolution asking for a nationwide referendum on physicians' Social Security.

14. Referred to a council for further study an Ohio resolution asking the A.M.A. to take a stand to exempt licensed physicians from any special requirements for receiving and using radioactive isotopes for medical purposes.

Catholic Hospital Group Hears Dr. Rourke Predict "Open Skies" Inspection

(*Continued From Page 65*)

attempt to review every chart but should select certain classifications of cases that frequently need review, such as appendectomies, gynecological procedures, and exploratory laparotomies, plus cases in which the pathologist has reported normal tissue removed.

2. Normal tissue itself is not evidence of an incorrect or unjustified procedure; the tissue committee must give careful evaluation to the clinical indications in each case.

3. All departments of the staff should be represented on the tissue committee, with the pathologist as an ex officio member.

4. Identification of doctors should be by code, and the doctor's name should not be revealed in connection with discussion of individual cases until the review is completed. Charts should not be circulated among committee members during the discussion.

5. Members of the tissue committee should be rotated semiannually or annually, so that all members of the staff have an opportunity to serve on this committee.

"The bulk of the member institutions of the Catholic Hospital Association are small or medium sized, well managed, clean and serve the needs of the cities in which they have been built," Dr. Reals, who is director of laboratories at the Wichita-St. Joseph Hospital, said at another session.

"The Sisters staffing these hospitals are loved by the grateful citizens of the area," he continued. "But, we may ask: Is this enough? How many hospitals have risen to eminence in the field of education? How many have excelled in basic medical research? Too few, must be the answer."

Speaking of in-hospital programs of medical education, Dr. Reals said, "We must clearly point out to our medical staffs that interns and residents are in our hospitals for service to the sick and for education, rather than service to the attending doctor."

PROPOSES ORGANIZATION

To integrate programs of education and research for Catholic hospitals, Dr. Reals proposed organization of an association "task force," composed of physicians, medical educators, and administrators who would travel to member hospitals for consultations with hospital personnel.

In another convention meeting, Earl J. Frederick, senior associate on the staff of Cresap, McCormick and Paget, New York management consultants, acknowledged that hospitals provide a personal service and thus have only limited opportunities to substitute machines for employes.

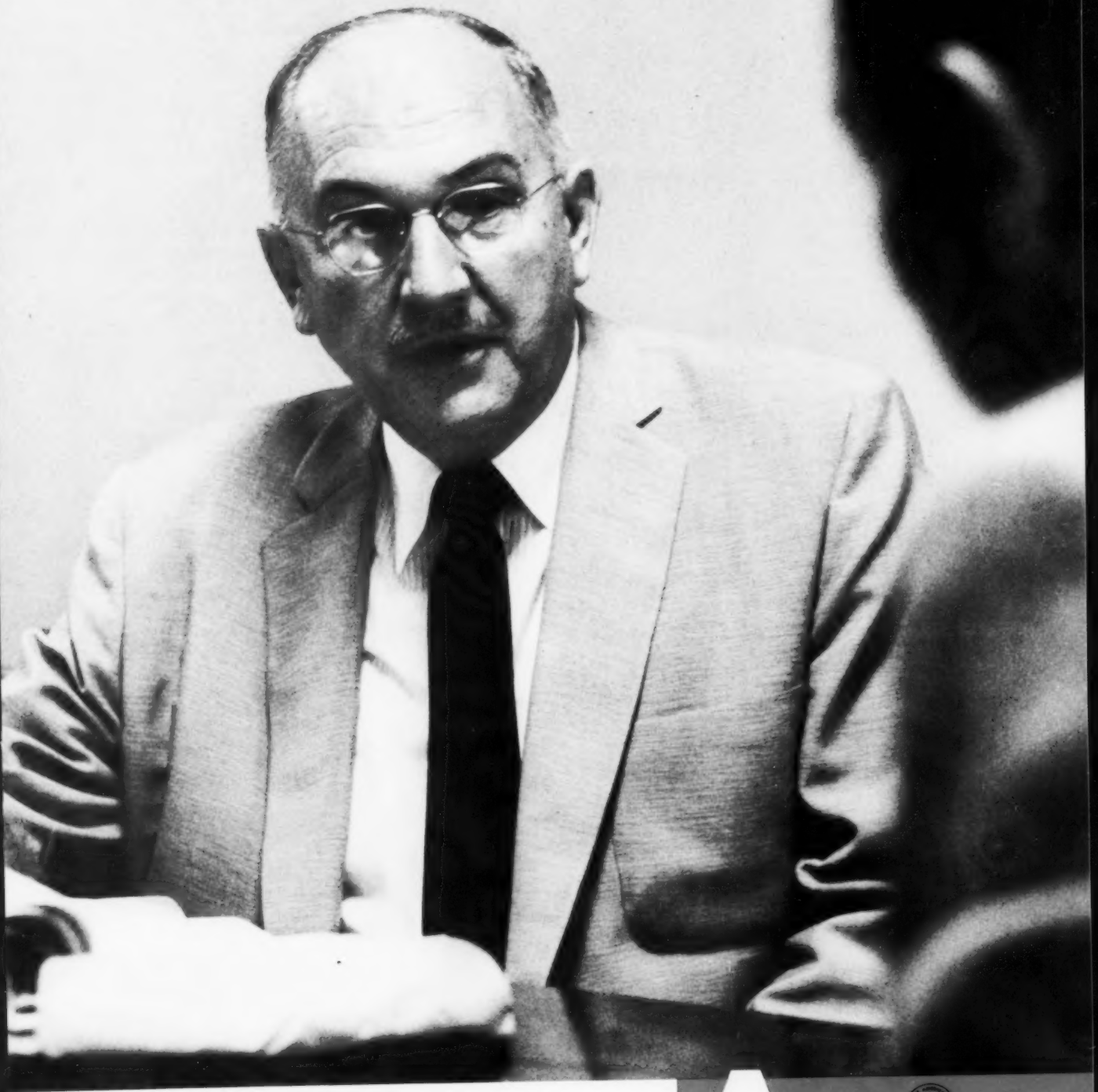
However, he added, there are many activities in the hospital which can be compared with those found in industry. "These repetitive type jobs may be found in the admitting, business, dietary, housekeeping, laundry and nursing departments," Mr. Frederick declared. "It is in these areas where the analyses used so successfully in industry have an application."

Hospitals have improved methods and efficiency generally through one of two types of improvement programs, Mr. Frederick said. These are:

1. A methods improvement program under the direction of a full-time or part-time person trained in methods engineering technics, or

2. A work simplification program to be used by hospital employes to improve their job performance.

What does American mean, "complete line" of laundry equipment?



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Hospital Plans Work Well in Kansas City Tornado

(*Continued From Page* 80)

corridor were lined carts and beds, end to end. Teams were waiting in emergency rooms and operating rooms, laboratory and x-ray were staffed, and blood was ready.

This picture of preparedness was repeated at hospital after hospital. A quick early swing by car around the major hospitals in the city revealed the same scene—teams waiting at ambulance entrances with carts and wheel chairs.

In surgery, emergency and outpatient departments, all the medical specialties were represented, plus many general practitioners, general surgeons, thoracic surgeons, neurosurgeons, orthopedists, urologists, anesthesiologists, pathologists, radiologists, and, of course, obstetricians and gynecologists. The stork is no respecter of catastrophe.

At the disaster scene there was chaos. A swath of utter destruction up to a thousand feet wide had been carved out mile after mile through an area of small and medium-sized homes, many of them without basements for shelter. There were no lights, no telephones. Where the twister struck, there was absolute leveling of everything that had stood in the spot. Streets and highways were choked and obliterated with the debris.

The injured were transported in any vehicle available — ambulances that had rushed to the scene, station wagons, private cars. They headed for the city over any route that was open, with no central dispatching. Their progress was impeded by the rush of cars into the area, a great many of them curious sightseers.

Two hospitals bore the brunt of the casualties: Menorah Medical Center, closest to the scene, received 92; and Independence Sanitarium and Hospital, on a direct route from the hard-hit Ruskin Heights area, got 52. St. Luke's handled 38 and St. Joseph, 35, with the remainder spread over 11 other hospitals.

Early in the evening the breakdown in dispatching became evident. The two hospitals having the biggest emergency departments and best prepared to cope with large numbers of casualties were being bypassed. They were University of Kansas Medical Center and General Hospital No. 1, both 500 bed institutions that have large house staffs.

At 319 bed Menorah there was seeming confusion at the emergency department, but a controlled confusion that pushed patients through with maximum efficiency. But facilities were being overtaxed and other hospitals, receiving few casualties, were only a few blocks and fewer minutes away. They sent doctors, nurses and supplies to Menorah, to help clear the jam.

Communications broke down almost completely for a time. Overloaded telephone exchanges clogged up, and it was difficult and at times impossible to get out-lines from hospitals. "Ham" radio operators reported at the disaster scene and at each hospital, but with no established plan they were not properly utilized. But at St. Joseph Hospital, a well known neurosurgeon, himself a "ham" operator, was able to direct head injury cases to the hospital and a number were handled there.

Even when telephones were working, calls plagued hospitals. Research, St. Mary's, and St. Luke's each received a call purported to be from the Grandview air base near the twister's path.

"Prepare to receive 150 casualties," the caller said. And St. Mary's was

asked to prepare surgery for a particularly bad head injury. It never showed up, nor did the 150 casualties each was told to expect.

Radio and television stations performed a great service in keeping the public, and hospitals, informed as to what was going on. They had mobile units at the scene, and newsmen at each hospital with busy microphones. Their cooperation with the Weather Bureau as the tornado advanced in its devastating course unquestionably saved many lives, at least among those who heard and heeded. Many did not.

As the night wore on, casualties thinned out. At overworked Menorah Medical Center, tired teams relaxed and found time for coffee, but surgery still went on and into the next morning. With inpatient facilities overcrowded, a number of patients at Menorah were transferred to other hospitals. During the height of the emergency, non-bedfast patients had wheeled their own beds down the corridors for use by disaster victims and had themselves prepared to sit out the night in waiting rooms and lobby.

Aftermath of the tornado brought some careful analysis and revealed some unpleasant facts.

As a major metropolitan area, Greater Kansas City was unprepared for a disaster even of this proportion, although hospitals individually had demonstrated readiness and could have taken from five to possibly even 10 times the number of casualties.

Lack of coordination among law enforcement agencies, civil defense, and others at the disaster scene slowed first aid and transportation of casualties.

Somewhere along the line there was none too accurate record keeping. The press reported some 200 victims received and treated at hospitals. Eliminating transfers, nearly 300 were actually handled, but names and addresses were not obtained at some hospitals on the minor injuries. Only numbers of patients were kept. At best count, tallied the day following the storm, 115 were admitted as inpatients, although again press reports didn't jibe, as 156 were reported.

The breakdown in communications was a serious problem. Failure to route patients to the several hospitals within a radius of a few blocks resulted in a pile-up at Menorah where patients had to wait, although they could have been handled immediately at the other hospitals. Communication between hospitals themselves should have corrected this, but it wasn't done.

Only at Independence was there a clear line of communication between hospital, police and ambulances at the scene—result of a carefully planned civil defense program.

The Kansas City Area Hospital Association, which reaches out in a circle 75 miles around the city, has expanded its disaster planning committee to take a fresh start at the problem.

In the absence of coordinated areawide planning by civil defense, hospitals should probably have taken steps long before to integrate their own operations. Recognizing that the handling of a disaster is a far bigger job than just medical and hospital care of casualties, they had waited for other groups to take leadership.

Now tackling the problem of communications, the disaster planning committee has got together with the Heart of America Radio Club, largest of the "ham" organizations in the area. Together, they are working out a short-wave "hospital network" which will place all hospitals in communication with one another, establish control points, and connect with any central control that may be developed.

How hospitals can be alerted is a serious question. Maybe the next disaster will come late at night when no radios are on. A 24 hour monitoring of police frequencies by at least two large hospitals is being considered as a solution.

Trained disaster teams from hospitals were needed for immediate dispatching to the scene. They weren't there, although a great many volunteers did show up and performed ably. Others tried to find out how they could help, but with no organized center of command, they stood around doing nothing.

Within individual hospitals, disaster plans need reevaluation and correction, although on the whole they functioned beautifully. But areawide, there was no plan at all. This realization came as a shock to the hospitals and to the community, which had failed to recognize the necessity for knitting together into an area authority all the components in the complex machinery of disaster handling.

To jerk a community and its hospitals out of lethargy and into serious joint planning, there's nothing like the hard kick of a real disaster experience.

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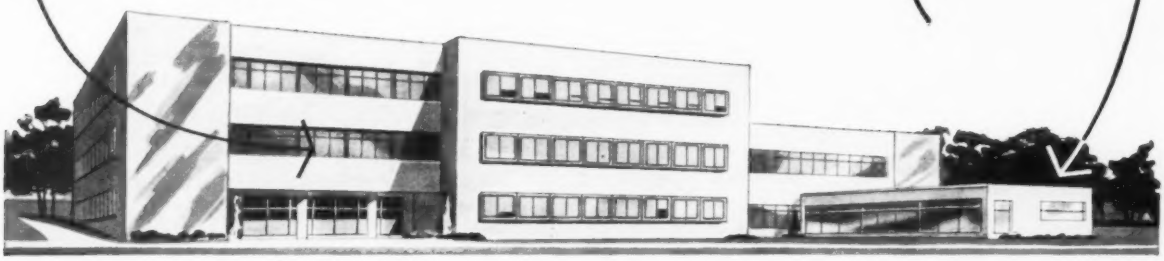

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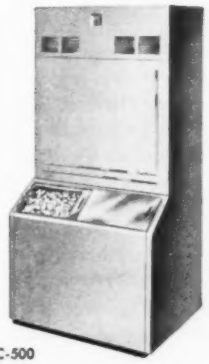

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NEWS DIGEST

Middle Atlantic Assembly Delegates Hear Needs of Future . . . Alabama Hospital Is First to Pay A.H.A. Dues Increase . . . Spiritual Care of Patients Stressed at Upper Midwest Conference . . . Schools Announce Student Residency Assignments

Speakers at Middle Atlantic Assembly Tell Needs of Hospital Field in Future

ATLANTIC CITY, N.J.—More than $10 billion will be needed by the nation's voluntary hospitals for capital improvements during the next 20 years because of the increasing rate of hospital admissions throughout the country. These figures, voiced by John T. Ryan Jr., Pittsburgh industrialist and president of the Hospital Council of Western Pennsylvania, sounded the keynote of the ninth annual meeting of the Middle Atlantic Hospital Assembly here May 22-24. Registration was reported at more than 3400 people.

Mr. Ryan was one of three speakers presenting the theme of the meeting, "What's Around the Corner for Hospitals." Ray E. Brown, immediate past president of the American Hospital Association, stressed the problem of our aging population. Life expectancy has increased half a year per year from 1925 to 1955, he stated; life expectancy at 65 is now another 14.5 years. The general population in this country does not pay for sickness; it is the minority that pays, and consequently it pays out of proportion, he said. In other words, hospital costs have no relationship to utilization, he added.

A paper prepared by Rep. Frances P. Bolton (R.-Ohio) was read before the delegates. Her discussion referred to sampling surveys sent out to 500 hospital administrators, indicating that hospital beds were idle because of lack of nurses.

According to Mrs. Bolton, this provides proof that the nursing dilemma has not been solved, that the shortage still remains and is serious, and that federal grants to aid nursing education are an emergency remedy only and do not provide any real answer.

Dr. Edward L. Bortz, chief of medicine at Lankenau Hospital, Philadelphia, said that hospitals must emphasize the positive aspects of health, adding that 50 per cent of the people now in hospitals would not be there if the public had been given the proper medical education by hospital personnel.

New officers of the Middle Atlantic Hospital Assembly, l. to r.: secretary, J. Harold Johnston, executive director, New Jersey Hospital Association; president, John W. Kauffman, administrator, Princeton Hospital, Princeton, N.J.; vice president, Dr. Ambrose P. Merrill, St. Barnabas Hospital for Chronic Diseases, New York, and treasurer, John F. Worman, executive secretary, Hospital Association of Pennsylvania.

Jerome Pollack of the social security department of the United Auto Workers said that the major problems facing prepayment plans are the constantly increasing cost of hospitalization and protection of patient and hospital interests. Labor does not favor prepayment plans based on experience ratings, he said, and hospitals should eliminate "deductible provisions" because they exert pressure on lower income workers. Outpatient services should be included in prepayment plans, he added.

Interspersing the general sessions were separate meetings held by the three constituent groups of the assembly, the state hospital associations of New Jersey, Pennsylvania and New York. The Pennsylvania group adopted a report urging hospitals to drop the designation "room and board" and use "daily service charge" or "general service charge."

"Hospitals," the report said, "should try to educate their publics to the dif-

(*Continued on Page* 160)

Alabama Delegate's Hospital First to Pay Dues Increase to A.H.A.

MONTGOMERY, ALA.—Carraway Methodist Hospital, Birmingham, Ala., was the first hospital to pay the dues increase voted by the American Hospital Association House of Delegates May 18, according to the *Bulletin* of the Alabama Hospital Association.

John L. Howell, Alabama delegate to the A.H.A. who read a statement criticizing A.H.A. policies at the May meeting, is administrator of the Carraway Hospital.

Frank Bynum, president of the Alabama Hospital Association, urged his state to become the first to pay the dues 100 per cent:

"Since only six or seven members registered any vocal or written opposition to the American Hospital Association dues increase proposal, the Alabama Hospital Association committee . . . instructed our delegate, John Howell, to vote for the temporary increase in dues of 50 per cent for four years.

"I conferred with our delegate for an hour before he left for the A.H.A. meeting and approved of his voting as instructed, as well as approving the critical analysis he made of the A.H.A. building contract and dues increase. These criticisms were constructive in nature.

"This dues increase notice has been sent to each A.H.A. hospital in the state, and I feel it will be for the betterment of both the national and state associations if the increase is paid as soon as possible," he said.

Massachusetts Officers

BOSTON.—The Rt. Rev. Msgr. A. C. Dalton, P.A., director of Catholic hospitals, archdiocese of Boston, was named president-elect of the Massachusetts Hospital Association, at its 21st annual meeting here May 9.

Dr. Dean A. Clark, general director of Massachusetts General Hospital, Boston, was installed as president.

Spiritual Care of Patients in Spotlight at the Tenth Anniversary Meeting of Upper Midwest

MINNEAPOLIS. — By way of celebrating its tenth anniversary, the Upper Midwest Hospital Conference, meeting here May 22 to 24, concentrated a great part of its attention on the spiritual care and guidance of the patient. Pastor, priest and rabbi contributed their views on the churches' responsibility to patients at one general session, and a sectional meeting for medical social workers was devoted to a discussion of the ways in which the social worker can help patients who are facing death. In addition, the needs of employes for recognition and morale building were considered at the opening session on "better leadership." Some 4500 persons attended the conference.

Opening the discussion on spiritual care of the patient, the Rev. Granger Westberg, associate professor of religion and health at the University of Chicago, ruefully acknowledged that "introducing psychiatric units into church hospitals is a slap in the face to the church. Has not the church for two thousand years concerned itself with broken hearts? And now a group of physicians, whose realm is usually the body, tells the church that they will take over the care of the inner man as well."

What is hardest for the church to accept, Mr. Westberg continued, is that "what these physicians have actually discovered is our own basic stock in trade, Love, and put it in the center of their therapy. There could be some stormy years ahead as physicians and clergy argue over the right to use love as therapy."

In Mr. Westberg's view, however, there is no danger of strife between minister and psychiatrist because "the clergy is humbly grateful to psychiatry for opening so many windows into the nature of man."

The next speaker, the Rev. Joseph J. Quinlan, chaplain of Hastings State Hospital, Hastings, Minn., didn't sound quite as humbly grateful. There was a definite wariness in his approach to collaboration between priest and psychiatrist, and he made very clear his opinion that each should stay in his own backyard.

"We cannot do each other's work," Father Quinlan emphasized. "Psychia-

(*Continued on Page* 157)

Donald W. Cordes, administrator of Iowa Methodist Hospital, Des Moines, succeeds Sister Rose Marie, administrator of St. Mary's Hospital, Pierre, S.D., as current president of the Upper Midwest Hospital Conference.

W. A. Barnhart Named President-Elect by Tennessee Hospitals

GATLINBURG, TENN. — William A. Barnhart, administrator of Maury County Hospital, Columbia, was named president-elect of the Tennessee Hospital Association here during the annual meeting May 30-June 1.

William A. Barnhart

Edgar H. Stohler, administrator of Memorial Hospital, Johnson City, was installed as president. Other officers are: first vice president, Frank Magoffin, Oakville Memorial Sanatorium, Memphis; second vice president, Charles Holmes, administrator of Campbell Clinic-Hospital, Memphis, and treasurer, Gene Kidd, administrator of Baptist Hospital, Nashville. New trustees are Robert Besserer, Nashville; Harold L. Peterson, Chattanooga, and Adelbert Dierks, Memphis.

President-Elect Barnhart reported that the hospital association has set up noninterest bearing loans for staff nurses who want advanced training and education.

Dr. Madison B. Brown, associate director of the American Hospital Association, said Medicare presents "a challenge to the hospitals to provide medical care at the lowest cost possible for servicemen and their dependents."

In a meeting on safety planning, Chief Herman Witt, inspector and fire prevention division of the Knoxville Fire Department, suggested that the administrator call on the local fire department to arrange for thorough inspections on a regular basis.

2300 Bed Replacement, Additional Personnel Planned for Bellevue

NEW YORK.—Conditions at Bellevue Hospital, recently the object of criticism by medical leaders and denials by city officials, have undergone more study by Dr. Morris A. Jacobs, commissioner of hospitals.

Dr. Jacobs was asked to make a report to Mayor Robert Wagner after medical leaders and lay groups at Bellevue had charged that inadequate physical facilities, lack of sufficient personnel, and shortages of medicine hampered medical care.

In Dr. Jacobs' report were requests from hospital department heads for 76 new employes, whose salaries would total $275,000 a year. Dr. Jacobs acknowledged that shortcomings and weaknesses existed, but said that charges of maltreatment of patients were "gross exaggeration." He also denied shortages of medicine, saying: "I cannot stress too strongly that at no time is a patient denied necessary medication. . . ."

Shortly before Dr. Jacobs' report was presented to the mayor, Public Works Commissioner Frederick H. Zurmuhlen revealed that architects have begun planning a 2300 bed replacement for Bellevue to cost $22 million. On April 25, the board of estimate had appropriated $85,000 for an architects' study to determine which buildings should be rebuilt or renovated.

Raymond P. Sloan, chairman of the New York City Hospital Visiting Committee, had urged an immediate architectural survey of Bellevue. The committee is a private citizens group that for 85 years has regularly visited city operated hospitals and reported to city and state officials.

Agreeing that much of the physical plant at Bellevue is antiquated, as was publicly charged, Mr. Sloan said the Visiting Committee had been stressing for two years the need for such a study.

"Not until such a survey has been completed can the necessary decisions be taken as to which buildings should be renovated, which should be torn down, and what types of new construction can be undertaken," Mr. Sloan, who is chairman of the board of directors of the The Modern Hospital Publishing Company, stated.

At the same time he noted that there had been many recent improvements at Bellevue and in the municipal hospital system as a whole.

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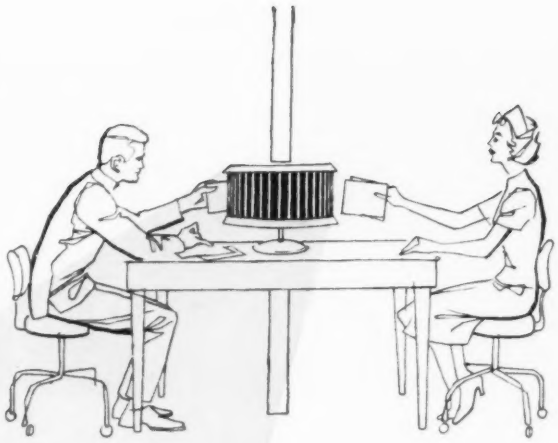

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GRADUATING CLASSES IN HOSPITAL ADMINISTRATION SCHOOLS

UNIVERSITY OF MINNESOTA

Students in hospital administration at the University of Minnesota: First row, left to right: Capt. LeRoy D. Werley Jr., Inkeri Vauraste, Ruth H. Inghram (instructor), James W. Stephan (associate director), Dr. Gaylord W. Anderson (director, School of Public Health), James A. Hamilton (director), Edith M. Lentz (assistant professor), Sister Mary Madonna, Lt. Jack McPhee. Second row: Ian F. Manning, Robert L. Bakken, Reginald A. Spindler, A. Kenneth Peterson, George M. Booth, James C. Ware, Joel T. Watson, Robert D. Strathy, William E. Johnson Jr., Raymond J. Schumacher, Lowell E. Palmquist. Third row: David V. Damberg, C. Robert Larson, Edmund K. Nelson, John R. Krismer, Lawrence M. Detmer, Richards M. Manuel, Wesley E. Bushman, Malcolm W. Hood, Lowell M. Vandervort, Virgil W. Marsh.

UNIVERSITY OF MICHIGAN

Administrative residents at the University of Michigan: Front row, left to right: Daniel N. Finch, William S. Atkinson, Bertram Zimmerman, Sister M. Francis Xavier, James M. Ensign, Robert C. Boardman, James Sullivan. Back row: E. J. Conners (instructor), John A. Russell, Wilfrid L. Hufton, Henry J. Morris, William S. Schmidt, John E. Gartland, Donald M. Schmaus, Jose T. Kamatoy, Walter J. McNerney (director).

ST. LOUIS UNIVERSITY

Members of the hospital administration class at St. Louis University: First row, left to right: Sister Agnes, D.C.; Sister DePaul, D.C.; Sister Clarus, F.S.M.; Sister St. Francis, F.M.M.; Sister Almarita, S.S.C.; Sister Florence, R.S.M.; Sister Ellen Patricia, S.C.; Sister Rita Louise, S.C.L.; Sister Patricia, O.S.F.; Sister Enda, S.S.J.; Sister Ruth, O.S.F.; Sister Rosalia, R.S.M.; Sister Helen, S.C. Second row: Sister Michael Marie, S.C.L.; Sister Theresa, C.S.J.; Sister Pieta, O.S.F.; Sister Adrian, C.S.J.; Antonio Rivera; William Milnes; Daniel Hicks; Charles E. Berry. Third row: John T. James; Robert McGlynn; Wilbur I. Christopher; Edward Bierman; Joseph Hiebel; James E. Johnson; Leo C. Bargielski; James McGuire; Stephen E. Dorn; Harold Hinderer. *Not in picture:* Sister Mary Eymard O'Conner; Sister Mary Salvatore Kavanagh.

UNIVERSITY OF TORONTO

Class in hospital administration at the University of Toronto: First row, left to right: R. B. Ferguson (lecturer), Dr. G. H. Agnew (professor and director), Eugenie M. Stuart (associate professor), H. G. Dillon (research fellow), Dr. W. D. Piercey (assistant professor). Second row: W. H. Schofield, H. A. Spencer, J. W. Short, Dr. J. P. McCabe. Third row: Dr. A. W. Taylor, Dr. B. L. P. Brosseau, R. E. Builder, R. A. Hudon. Back row: Dr. J. K. Morrison, Dr. J. V. Roberts, R. I. Crickmore, K. S. McLaren.

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St. Louis University Announces Residencies

ST. LOUIS.—Students in the hospital administration course at St. Louis University have been assigned as follows:

Leo C. Bargielski to St. Joseph's Hospital, Fort Worth, Tex.; Sister M. Enda Caldwell, C.S.J., to St. Mary's-Corwin Hospital, Pueblo, Colo.; Sister Mary St. Francis Condon, F.M.M., to St. Mary's Hospital, San Francisco; Sister Rita Louise Cunningham, S.C.L., to St. Joseph's Hospital, Syracuse, N.Y.; Stephen E. Dorn to City Hospital, St. Louis; Sister Mary Adrian Fisch, C.S.J., to Providence Hospital, Seattle; Sister M. Patricia Florkoski, O.S.F., to Sacred Heart Hospital, Yankton, S.D.

Sister M. Rosalia Fried, R.S.M., to St. Vincent Hospital, Worcester, Mass.; Joseph C. Hiebel to Malden Hospital, Malden, Mass.; James E. Johnson to St. Mary's-Corwin Hospital, Pueblo, Colo.; Sister Almarita Kuzmickas, S.S.C., to St. Mary's Hospital, Troy, N.Y.; Sister M. Pieta Laufer, O.S.F., to St. Vincent's Hospital, New York; Sister M. Clarus Loughlin, F.M.M., to St. Mary's Hospital, San Francisco; Sister Ellen Patricia Meade, S.C., to Mercy Hospital, Baltimore.

Sister M. Theresa Murphy, C.S.J., to St. Francis Hospital, Hartford, Conn.; Sister Agnes McPhee, D.C., to Hotel Dieu, New Orleans; Sister Michael Marie O'Leary, S.C.L., to St. Joseph's Hospital, Phoenix, Ariz.; Antonio C. Rivera to St. Louis City Hospital, St. Louis; Sister M. Florence Salatka, R.S.M., to St. Vincent's Hospital, New York; Sister Mary Helen Tobin, S.C., to St. Elizabeth Hospital, Youngstown, Ohio; Sister DePaul Williams, D.C., to St. Vincent's Hospital, Birmingham, Ala.

Sister Mary Eymard O'Conner is now in residency at St. Mary's Hospital, San Francisco, and Sister Mary Salvatore Kavanagh is in residency at St. Francis Hospital, Hartford, Conn.

University of Minnesota Announces Residencies

MINNEAPOLIS. — Residency assignments for students in the hospital administration course at the University of Minnesota have been announced:

Robert L. Bakken to Memorial Hospital of South Bend, South Bend, Ind.; George M. Booth to Highland Hospital, Rochester, N.Y.; Wesley E. Bushman to Stormont-Vail Hospital, Topeka, Kan.; David V. Damberg to Rhode Island Hospital, Providence, R.I.; Lawrence M. Detmer to Johns Hopkins Hospital, Baltimore; Malcolm W. Hood to San Jose Hospital, San Jose, Calif.

William E. Johnson Jr. to Swedish Hospital, Minneapolis; John R. Krismer to Charles T. Miller Hospital, St. Paul; C. Robert Larson to St. Barnabas Hospital, Minneapolis; Lt. Jack C. McPhee to 3700th U.S.A.F. Hospital, Lackland Air Force Base, Tex.; Ian F. Manning to Vancouver General Hospital, Vancouver, B.C.; Richards M. Manuel to St. Luke's Hospital, Milwaukee.

Virgil W. Marsh to Minneapolis General Hospital, Minneapolis; Edmund K. Nelson to Bethesda Hospital, St. Paul; Lowell E. Palmquist to Fairview Hospital, Minneapolis; A. Kenneth Peterson to Mount Sinai Hospital, Minneapolis; Raymond J. Schumacher to Syracuse Memorial Hospital, Syracuse, N.Y.; Sr. Mary Madonna to University of Minnesota Hospitals, Minneapolis.

Reginald A. Spindler to Rochester Methodist Hospital, Rochester, Minn.; Robert D. Strathy to Abbott Hospital, Minneapolis; Lowell M. Vandervort to Baylor University Hospitals, Dallas, Tex.; James C. Ware to Baptist Memorial Hospital, Memphis, Tenn.; Joel T. Watson to Strong Memorial Hospital, Rochester, N.Y.; Capt. Leroy D. Werley Jr. to 3700th U.S.A.F. Hospital, Lackland Air Force Base, Tex.

Michigan Students Are Assigned to Hospitals

ANN ARBOR, MICH.—Students from the University of Michigan's program in hospital administration who are scheduled to begin their administrative residencies this summer are as follows:

William S. Atkinson to Blodgett Memorial Hospital, Grand Rapids, Mich.; Robert C. Boardman to Newton-Wellesley Hospital, Newton Lower Falls, Mass.; James M. Ensign to Henry Ford Hospital, Detroit; Daniel N. Finch to St. Luke's Hospital, Toledo, Ohio; John E. Gartland to University Hospital, Ann Arbor, Mich.; Wilfred L. Hufton to New York University-Bellevue Medical Center, New York; Jose T. Kamatoy, special student from the Philippines.

Henry J. Morris to Grace Hospital, Detroit; John A. Russell to Evanston Hospital, Evanston, Ill.; Donald M. Schmaus to Milwaukee County Hospital, Milwaukee; William S. Schmidt to Grace-New Haven Community Hospital, New Haven, Conn.; James Sullivan, graduating class of 1957; Bertram Zimmerman to Delaware Hospital, Wilmington, Del.; Sister M. Francis Xavier to Provincial House, Detroit.

UNIVERSITY OF CHICAGO

Class of 1956-57, University of Chicago (1st row, left to right): Dr. Mathias da Gama e Silva, William H. Ennis, Carl I. Bergkvist; (2d row, left to right): Francisco D. Sabichi, William J. Fowler, Dr. Richard G. Dunning, David M. Hatfield; (3d row, left to right): James R. Stricker, Marshall C. Petring, Jerry B. Boyle, Everett V. Fox; (4th row, left to right): Vernon W. Forsman, associate director of the program; So V. Zimmermann, coordinator of the program, and Ray E. Brown, director of the program. *Not in photo:* Peter S. Hutchinson.

University of Chicago Announces Residencies

CHICAGO.—Students in hospital administration at the University of Chicago have been appointed to residencies as follows:

Carl I. Bergkvist to Dixon State Hospital, Dixon, Ill.; Jerry B. Boyle to University Hospitals, Cleveland; Dr. Richard G. Dunning to Alameda County Hospital System, Oakland, Calif.; William H. Ennis will return to active administration.

Other assignments are: William J. Fowler to Dallas City-County Hospital System, Dallas, Tex.; Everett V. Fox will return as administrator, Kate Bittings Reynolds Hospital, Winston-Salem, N.C.; Dr. Mathias da Gama e Silva to Ohio State University Hospitals, Columbus; David M. Hatfield to University of Chicago Clinics; Peter S. Hutchinson to Iowa Methodist Hospital, Des Moines; Marshall C. Petring to Cleveland City Hospital; Francisco D. Sabichi to University of Indiana Medical Center, Indianapolis; James R. Stricker to Presbyterian-St. Luke's Hospital, Chicago.

University of Toronto Announces Assignments

TORONTO, ONT.—Resident appointments for students in the class in hospital administration at the University of Toronto have been announced by the directors of the school as follows:

Dr. B. L. P. Brosseau to Toronto Western Hospital and Sunnybrook Hospital, Toronto, Ont.; R. E. Builder to Humber Memorial Hospital, Weston, Ont.; R. I. Crickmore to Kaiser Foundation Hospital, Vallejo, Calif.

R. A. Hudon is assigned to Kitchener-Waterloo Hospital, Kitchener, Ont.; Dr. J. P. McCabe to Toronto East General Hospital and Sunnybrook Hospital, Toronto, Ont.; K. S. McLaren to Toronto East General Hospital, Toronto, Ont.

Dr. J. K. Morrison to Victoria Hospital and Westminster Hospital, London, Ont.; Dr. J. V. Roberts to Hamilton General Hospital, Hamilton, Ont., and Shaughnessy Hospital, Vancouver, B.C.; W. H. Schofield to Mercer Hospital, Trenton, N.J.; J. W. Short to Royal Jubilee Hospital, Victoria, B.C.; H. A. Spencer to Ottawa Civic Hospital, Ottawa, Ont.; Dr. A. W. Taylor to Toronto General Hospital, Toronto, Ont.

Upper Midwest Conference Holds 10th Anniversary Meeting in Minneapolis

(*Continued From Page* 150)

trists are concerned about the training of chaplains. Some of them consider themselves therapists and neglect the religious needs of the patients. Chaplains, on the other hand, complain that psychiatrists try to be clergymen."

All patients—Jews, Protestants or Catholics—find themselves in an abnormal situation when they are in the hospital, according to Rabbi Albert G. Minda of Temple Israel in Minneapolis. The rôle of the rabbi, as he sees it, is to serve as interpreter between patient and hospital and to provide the patient with everything possible to lessen the patient's sense of abnormality.

Of all the spiritual problems encountered in hospitals, probably none is more difficult for both patients and staff than helping the patient, who is facing death, and his family adjust to the situation. An overflow crowd of social workers and administrators heard Frances Watson of the department of preventive medicine and public health, Washington University, St. Louis, tell what the social worker can do—and must not attempt to do—in such cases.

"The case worker," said Miss Watson, "sees herself as helping the patient work out his feelings about approaching death after he knows about it. She loses sight of the fact that a patient has a right to avoid knowledge of his illness or prognosis, or to avoid hearing about it until he is ready to face it.

"It is imperative for the case worker to realize that she cannot change the patient's downhill course," Miss Watson continued. "She can only help him mobilize his strengths to meet the situation in the way that will be most comfortable for him. She must realize, too, that she cannot change the situation for the relatives, but that if they can accept her service she may be able to help them handle their feelings and problems so that they can meet the responsibilities they must assume during the period of terminal illness."

At the Wednesday morning session devoted to human relations and public relations, the audience learned that most of their communication problems could be solved if they would just stop talking and listen. "The greatest single block to personal communications is man's inability to listen understandingly and sympathetically to another person," asserted Russell Rosendahl, Dale Carnegie instructor and personnel director of Northwestern Bell Telephone Company, Minneapolis.

Listening, Mr. Rosendahl explained, is not a passive act; it is hard work and requires concentration and practice. "It means putting ourselves in the world of the speaker, and once we are in his shoes the attempt to think as he thinks and feel as he feels becomes a process of discovery and adventure in human relations. In fact, it is human relations in action."

New officers elected for the 1957-58 season were: president, Donald W. Cordes, administrator, Iowa Methodist Hospital Des Moines (succeeding Sister Rose Marie, administrator, St. Mary's Hospital, Pierre, S.D.); vice president, Harold C. Mickey, director, Rochester Methodist Hospital, Rochester, Minn.; new members of the board of trustees, Robert Howe, administrator, Billings Deaconess Hospital, Billings, Mont., and Sister Mary Innocentia, administrator, St. John's Hospital, Huron, S.D. Glen Taylor was reelected executive secretary of the conference.

COMING EVENTS

AMERICAN ASSOCIATION OF MEDICAL RECORD LIBRARIANS, Schroeder Hotel, Milwaukee, Oct. 7-10.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Atlantic City, N.J., Sept. 28-30.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Regional Membership Conferences: Region 12, Shamrock Hilton Hotel, Houston, Tex., August 19-23; Region 9, Chicago, Nov. 11-15.

AMERICAN COLLEGE OF OSTEOPATHIC HOSPITAL ADMINISTRATORS, St. Louis, Oct. 26.

AMERICAN HOSPITAL ASSOCIATION, national convention, Convention Hall, Atlantic City, N.J., Sept. 30-Oct. 3.

AMERICAN NURSING HOME ASSOCIATION, Ambassador Hotel, Atlantic City, N.J., Oct. 7-10.

AMERICAN OSTEOPATHIC HOSPITAL ASSOCIATION, St. Louis, Oct. 27-30.

BRITISH COLUMBIA HOSPITALS' ASSOCIATION, Vancouver Hotel, Vancouver, Oct. 15-18.

CALIFORNIA HOSPITAL ASSOCIATION, Lafayette Hotel, Long Beach, Oct. 30-Nov. 1.

COLORADO HOSPITAL ASSOCIATION, Hotel Denver, Glenwood Springs, Oct. 10, 11.

CONNECTICUT HOSPITAL ASSOCIATION, Conn. Light & Power Co., Berlin, Conn., Nov. 13.

INDIANA HOSPITAL ASSOCIATION, Student Union, Univ. of Ind. Medical Center Campus, Indianapolis, Oct. 9, 10.

KANSAS HOSPITAL ASSOCIATION, Broadview Hotel, Wichita, Nov. 14, 15.

MARYLAND-DISTRICT OF COLUMBIA-DELAWARE HOSPITAL ASSOCIATION, Hotel Shoreham, Washington, D.C., Nov. 6-8.

MISSISSIPPI HOSPITAL ASSOCIATION, Hotel Buena Vista, Biloxi, Oct. 9-11.

NEBRASKA HOSPITAL ASSOCIATION, Cornhusker Hotel, Lincoln, Oct. 17, 18.

NORTH CAROLINA HOSPITAL ASSOCIATION, Battery Park Hotel, Asheville, Aug. 9.

ONTARIO HOSPITAL ASSOCIATION, Royal York Hotel, Toronto, Oct. 28-30.

OREGON ASSOCIATION OF HOSPITALS, Eugene Hotel, Eugene, Nov. 4, 5.

SOUTH DAKOTA HOSPITAL ASSOCIATION, fall meeting, Sheraton Cataract Hotel, Sioux Falls, Oct. 15, 16.

VERMONT HOSPITAL ASSOCIATION, Long Trail Lodge, Pico Peak, Rutland, Oct. 18.

VIRGINIA HOSPITAL ASSOCIATION, Hotel Chamberlin, Old Point Comfort, Nov. 15, 16.

WEST VIRGINIA HOSPITAL ASSOCIATION, Greenbriar Hotel, White Sulphur Springs, Aug. 1-3.

WORKSHOP ON ASEPTIC TECHNIC, University of Minnesota Center for Continuation Study, Minneapolis, Sept. 16-26.

1958

ALABAMA HOSPITAL ASSOCIATION, Hotel Stafford, Tuscaloosa, Jan. 23, 24.

SOUTHEASTERN HOSPITAL CONFERENCE, Hotel Fountainbleau, Miami Beach, Fla., May 14-16.

TEXAS HOSPITAL ASSOCIATION, Statler-Hilton Hotel, Dallas, May 6-8.

Middle Atlantic Speakers Discuss Needs of Future

(*Continued From Page* 148)

ferences in value and cost between a hotel room rate and the hospital charge for general service."

Middle Atlantic Assembly officers named at the convention were: president, John W. Kauffman, administrator, Princeton Hospital, Princeton, N.J., succeeding George A. Hay of Pennsylvania; vice president, Dr. Ambrose P. Merrill, superintendent, St. Barnabas Hospital for Chronic Diseases, New York; secretary, J. Harold Johnston, executive director, New Jersey Hospital Association, and treasurer, John F. Worman, executive secretary, Hospital Association of Pennsylvania.

New Jersey Hospital Association officers, l. to r.: executive director, J. Harold Johnston; president, Ralph E. Vannozzi; vice president, David V. Carter, and treasurer, Nelson O. Lindley.

Following are New Jersey officers: president, Ralph E. Vannozzi, Bridgeton, to succeed Cora E. Gould, Orange; president-elect, Dr. Abram L. Van Horn, Far Hills; vice president, David V. Carter, Neptune; treasurer, Nelson O. Lindley, Somerville; executive director, J. Harold Johnston, Trenton; trustees, Arnold Lane, Point Pleasant, and Robert E. Heinlein, Summit.

The Pennsylvania group elected: president, James C. Kirk, Pottsville, to succeed C. Robert Youngquist, Sharon; first vice president, Walter J. Rome, Pittsburgh; second vice president, Mabel Barron, Ellwood City; reelected treasurer, Joseph W. Bishop, Scranton; renamed executive director, John F. Worman, Harrisburg, and trustees, Joseph F. Friedheim, New Castle, and Morris F. George, Abington.

New York will have for its new officers: president, Lawrence J. Bradley, Rochester, to succeed Dr. Ambrose P. Merrill, New York; first vice president, Theodore F. Childs, New York; second vice president, Carlton B. Shannon, Watertown; secretary, Alex E. Norton, New Rochelle; reelected treasurer, Moir P. Tanner, Buffalo, and trustees, Alvin J. Binkert, the Rev. Patrick J. Frawley, both New York, and Harry C. F. Gifford, Glen Cove.

ABOUT PEOPLE

(*Continued From Page* 83)

Alvin J. Binkert, vice president and general manager of the Presbyterian Hospital, New York, has been named executive vice president. Associated with the hospital for 20 years, Mr. Binkert has been controller and assistant vice president of administration for the institution. He is a member of the American College of Hospital Administrators, a member of the board of governors of the Greater New York Hospital Association, and a trustee of the Hospital Association of New York State.

Joseph D. McGee

Joseph D. McGee has been appointed to the newly created post of assistant administrator of SS. Mary and Elizabeth Hospital, Louisville, Ky. He recently completed a two-year residency in hospital administration within the Louisville Medical Center and received his master's degree from Northwestern University. He is a member of the American Hospital Association.

William F. Andrews has resigned as administrator of Blount Memorial Hospital, Maryville, Tenn., to become administrator of the Wake County Hospital Authority, Raleigh, N.C. He will be succeeded in Maryville by **E. A. Herron,** assistant director of Vanderbilt University Hospital, Nashville, Tenn. Both are graduates of the Duke University program in hospital administration.

Joseph F. Farrell has been appointed to the newly created position of associate director of Germantown Dispensary and Hospital, Philadelphia. Mr. Farrell has served as controller and as assistant director since 1948.

W. R. Brungard Jr. has been appointed assistant administrator of St. Luke's Hospital, Davenport, Iowa, where he is now an administrative resident. Mr. Brungard received his master's degree in hospital administration from the State University of Iowa.

David D. Boyd has been appointed assistant administrator of Mary Hitchcock Memorial Hospital, Hanover, N.H. Mr. Boyd, who is a graduate of the Yale University program in hospital administration, formerly was administrative assistant at the hospital.

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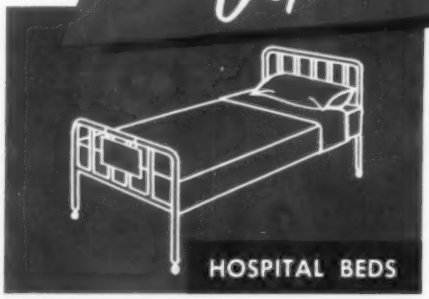
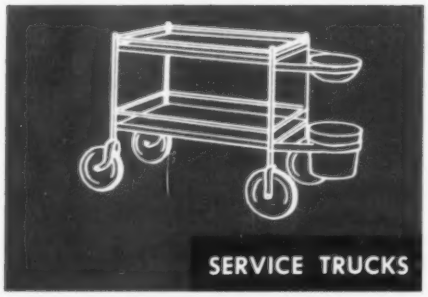
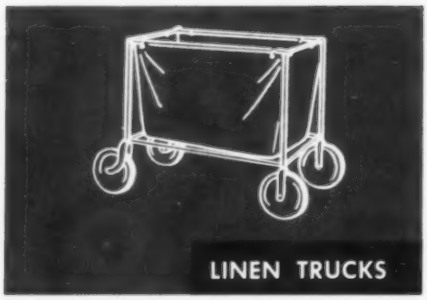


HOSPITAL BEDS



SERVICE TRUCKS



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The only caster with proven performance for outstanding . . .

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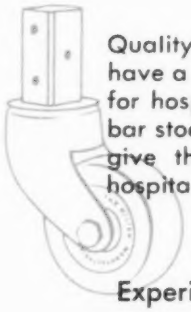

Quality built for continuous performance, Kilian casters have a record of use that makes them the natural choice for hospital service. All metal parts are machined from bar stock and all ball bearing parts fully heat treated to give the long life and trouble-free service vital for hospital use.

Experiences of hospitals equipped with Kilian casters give adequate proof of the smooth-rolling, lasting dependability that can be expected.

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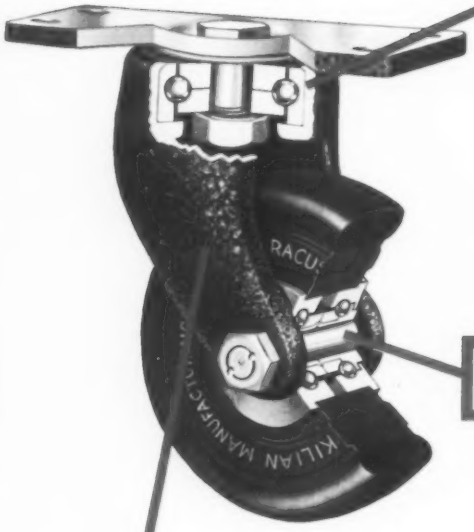

SILENT POSITIVE SWIVELING

to provide safe, easy movement —

Ideally suited for hospital service, Kilian casters are uniformly processed to include features that result in positive swiveling, and easy, quiet rolling action. A self-contained swivel bearing in the forks eliminates the possibility of loosening of the bearing and loss of steel balls. In the wheels, ball bearings instead of plain metal bushings reduce friction and contribute to better and sure, easy movement.

STRONG, DURABLE STRUCTURE

to eliminate time-consuming maintenance problems . . .

All metal parts (wheel bearings, swivel assemblies, axles and nuts) are machined from bar stock, with bearing surfaces fully heat treated for longer life. Only Grade A steel balls are used, held to a tolerance of .0005". The two wheel bearings are of the labyrinth sealed type and are fully grease packed for life to lock out all dirt. Swivel forks, stationary forks, as well as brake parts are malleable iron which will take many times the abuse of steel stampings.

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Bill L. Hamilton

Bill L. Hamilton, administrative assistant at the Methodist Hospital, Houston, Tex., has been appointed assistant administrator of All Saints Episcopal Hospital, Fort Worth, Tex. Mr. Hamilton is a graduate of the hospital administration program at Washington University, a member of the American Hospital Association, and a nominee of the American College of Hospital Administrators.

A. L. Howarth has resigned as administrator of Mary Bridge Children's Hospital, Tacoma, Wash. Mr. Howarth, who is life honorary president of the Washington State Hospital Association, has been a hospital administrator and administrative consultant for 25 years.

Daniel I. Kahn has been named assistant administrator of Culver City Hospital, Culver City, Calif. He formerly was administrative assistant. **Eugene Stevens** will remain at the hospital as administrative assistant. Mr. Stevens retired from the navy medical service corps in July 1956, after many years of service.

Phillip R. Roth has become administrator of Tri-State Memorial Hospital, Clarkston, Wash. He formerly was administrator of Ocean Beach Hospital, Ilwaco, Wash.

Paul R. Donnelly

Paul R. Donnelly has been appointed assistant director of Grant Hospital in Chicago. Mr. Donnelly served as job analyst during 1955-56 and during the last year has been administrative resident at the hospital. He is a graduate of the program in hospital administration at Northwestern University.

Department Heads

Julia Nolte has been named personnel director of Mercy Hospital-Street Memorial, Vicksburg, Miss., succeeding **Thomas L. Askew,** whose appointment to a similar position at King's Daughters' Hospital, Yazoo, Miss., was reported in the June issue of The Modern Hospital.

Judith Kramer has been appointed chief of the department of physical therapy at Louis A. Weiss Memorial Hospital, Chicago. A graduate of the physical therapy department in the Washington University School of Medicine, St. Louis, Miss Kramer has been a member of the hospital staff since June 1956.

Miscellaneous

Margaret G. Arnstein, chief of public health nursing in the U.S. Public Health Service, has been named a visiting professor at Yale University for the spring of 1958. She will be the first visiting professor on the Annie W. Goodrich endowment, a new faculty post established in memory of the founder and first dean of the Yale School of Nursing.

Helen Nahm, associate director of the National League for Nursing and director of its division of nursing education, has resigned to become dean and professor of nursing at the University of California. She is expected to begin her new duties in 1958. Miss Nahm has previously been director of the schools of nursing at the University of Missouri and Hamline University, and professor and director of the division of nursing education at Duke University.

(*Cont. on Page* 162)

Deaths

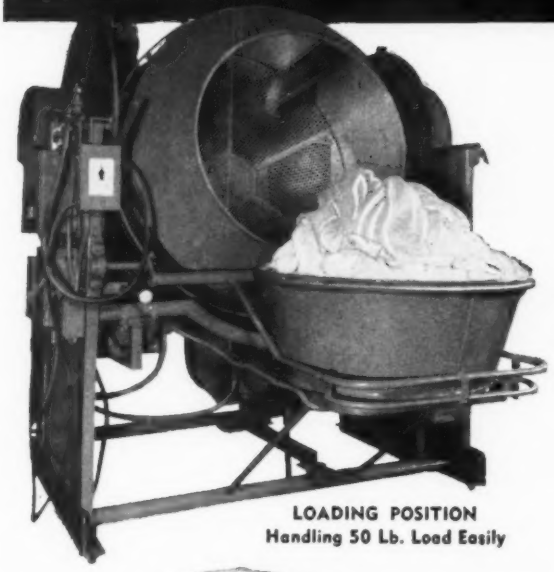
Dr. Haven Emerson, pioneer public health physician, died in May at the age of 82. He entered the field of public health in 1914, when he joined the New York City Health Department as deputy commissioner. Two years later he was named commissioner and was instrumental in organizing what is now the American Heart Association. During World War I he served as chief epidemiologist with the American Expeditionary Forces, won the Distinguished Service Medal from the United States, and was made a knight of the French Legion of Honor. Professor emeritus of public health practice at Columbia University, he retired as head of the school in 1940, after 18 years of teaching. A former president of the American Public Health Association, Dr. Emerson received a special Lasker award in 1949 for distinguished service in the field of public health. He was a trustee of the Oberlaender Trust and the W. K. Kellogg Foundation, and had been a member of the New York Board of Health since 1937.

Nell V. Beeby

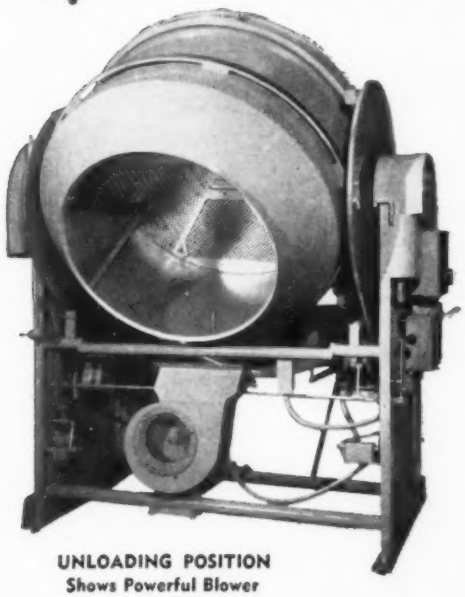
Nell V. Beeby, R.N., executive editor of the *American Journal of Nursing,* died May 16. She was 60 years old. Miss Beeby had been associated with the publication for more than 20 years, beginning her work in 1936 as an assistant editor. Her special interest was international nursing, and in 1924 she worked as a nurse supervisor and instructor in China. At the time of her death she was completing a survey of the world's nursing publications. In February Miss Beeby received the Mary Adelaide Nutting medal in recognition of her achievements in nursing. She was a member of the American Nurses' Association, National League for Nursing, American Hospital Association, and American Public Health Association.

Katherine Tucker, a leader in public health nursing and nursing education, died June 7 at the age of 72. At one time she was executive director of the National Organization for Public Health Nursing, and she served as director of the department of nursing education and professor of public health nursing at the University of Pennsylvania for 14 years.

Every Time Wages Go Up A Purkett PCT* Pays For Itself That Much Faster



LOADING POSITION
Handling 50 Lb. Load Easily



UNLOADING POSITION
Shows Powerful Blower

It's a case of simple mathematics. A survey will show what employees can be eliminated in the manual shake-out operation by using a Purkett Pre-Drying Conditioning Tumbler, and you multiply that figure by your wage scale, and there you are.

Note that you may get help on your problems from a specialized engineer of Purkett's Consulting Service, without obligation.

Of course, the PCT* means a lot more than that to every operator . . . for example:

1. Purkett's PCT* will keep your ironers working at full capacity with the quality of ALL work improved.

2. Re-runs will be eliminated. All excessive moisture will be removed and the remainder properly distributed.

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Write for descriptive literature

***PRE-DRYING CONDITIONING TUMBLER**

Naturally it's a PURKETT

Purkett equipment is sold by ALL Major Laundry Machinery Manufacturers and by

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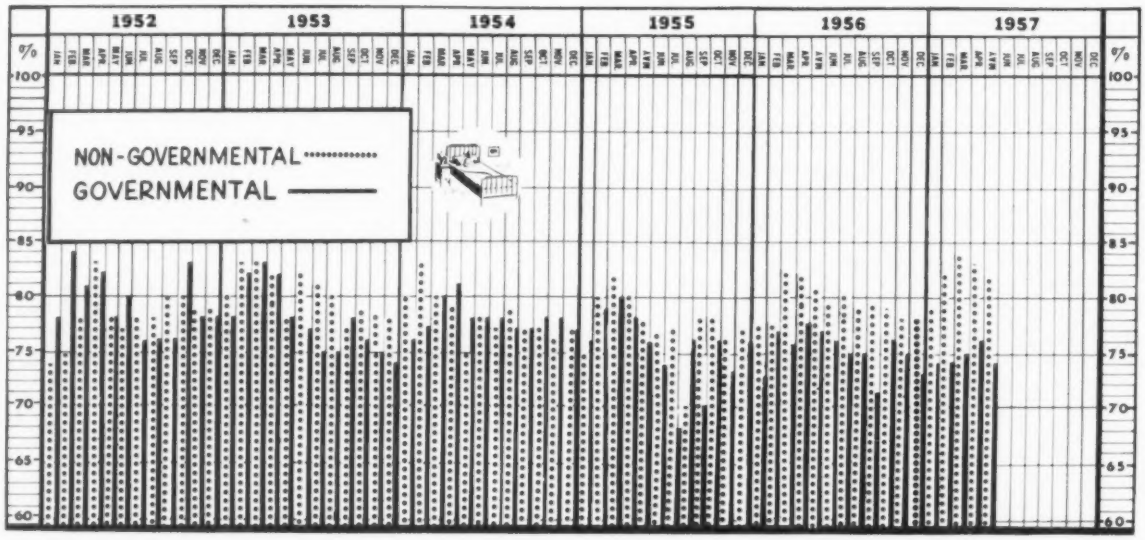
DEPENDABLE PRE-DRYING CONDITIONING TUMBLERS

Current Hospital Building Projects Number 73



Voluntary hospital reports to the Occupancy Chart for May show they were filled to 82.3 per cent of capacity —a 1.4 per cent increase over occupancy reported for May 1956. Government hospitals reported 73.9 per cent —a decrease of 2.4 per cent from occupancy reported a year ago.

The 73 current building projects reported for the period May 13 through June 10 totaled $69,391,330, bringing the total for the year thus far to $359,662,100. For the corresponding period last year, construction totaled $95,180,401 and brought the 1956 total by June 11 to $364,951,211. Included in the current projects are 21 hospitals and 45 additions to existing facilities.

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Standard Lengths • ATRAUMATIC® Needles

Cuts preparation time 33⅓%[1]

no more awkward tubes or reels . . . simple technic frees nurses for other duties.

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no kinks or weak spots from tight reel winding . . . less handling required . . . may be removed from envelopes as needed to prevent drying out . . . needle points and cutting edges are better protected.

Saves money[1]

fewer sutures damaged or opened unnecessarily . . . 30% less glove damage . . . takes *half* the storage space . . . *costs no more than tubes!*

1. Alexander, Edythe L.: Mod. Hosp., May, 1957.

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POSITIONS WANTED

ADMINISTRATOR—8 years, 250-bed general hospital; chief accountant, administrative assistant, 4 years assistant; experience includes planning, equipping, staffing new hospital; NACHA-34. Apply MW 129, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

ANESTHETIST—Male M.D.; experienced in all phases of anesthesia; now available; salary or fees. Apply MW 199, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Ill.

ASSISTANT ADMINISTRATOR—Age 30; extensive background in medicine, nursing and hospital pharmacy; well established by 8 years of college supplemented by practical experience; awarded degrees in Arts and Sciences and pharmacy; now practicing hospital pharmacy, but seeking better utilization of full capabilities. Apply MW 198, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

PATHOLOGIST—Certified CP and PA; age 40; 11 years experience in general hospital; desires new hospital position on fee for service or percentage basis. Apply MW 197, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

The Medical Bureau

M. BURNECE LARSON—DIRECTOR

Telephone DElaware 7-1050

900 NORTH MICHIGAN AVENUE, CHICAGO

ADMINISTRATOR—Medical; M.P.H. (Hospital Administration); M.S. (Health and Physical Education); eight years, assistant superintendent, 1200-bed general hospital; three years, administrative staff, one of leading organizations in graduate medicine.

ADMINISTRATOR—M.H.A.; four years, associate director, teaching hospital, assisting in building program increasing capacity from 200 to 400; six years, director, 225-bed hospital.

ASSISTANT ADMINISTRATOR—B.S. (Business Administration); M.H.A.; since completing residency, teaching hospital, has served as its personnel director, lecturer and coordinator, program in hospital administration.

PERSONNEL DIRECTOR—B.A.; three years' teaching experience; three years, assistant personnel director and director, supervisors' training program; 900-bed hospital.

COMPTROLLER — B.S.; accounting manager (five years), comptroller (two years), 650-bed hospital; two years, director department, 1000-bed hospital.

FOOD SUPERVISOR—B.S. (Major: Institutional Management and Home Economics); 10 years' experience.

PATHOLOGIST—M.S. (Pathology); Diplomate (Pathologic Anatomy; clinical Pathology); eight years, director, pathology, 250-bed hospital; recently completed military service.

MEDICAL BUREAU—*Continued*

RADIOLOGIST—University hospital training in radiology including radioisotopes; M.S. (Radiology); four years, group association; Diplomate (Diagnostic and Therapeutic Radiology).

OUR 61st YEAR

WOODWARD

Medical Personnel Bureau

FORMERLY AZNOE'S

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• ANN WOODWARD • *Director*

ADMINSTRATOR—B.S., (Hospital Administration); year's hospital residency; 4 years, administrative office and assistant administrator, 400-bed, research and teaching hospital; 4 years, administrator, 150-bed children's hospital; excellent training and experience; active hospital affairs, local and National levels; Member ACHA.

ASSISTANT ADMINISTRATOR—A.A. (Business Administration), M.S.H.A.; 3 years, medical service corps officer, USA; 1 year, hospital purchasing agent; 2 years, preceptee and rotating administration residency, 200-bed general hospital; excellent training; prefers California; consider other locality; age 25.

PATHOLOGIST—Diplomate, anatomy; qualified C.P.; 32; 4 years experience, pathology as chief,, 300-bed hospital and director, pathological laboratory, large city; prefers % arrangement; west or midwest.

RADIOLOGIST—4 years, associate radiologist, fully approved JCAH hospital, 500-beds; prefers Indiana; age 35; Diplomate.

INTERSTATE MEDICAL PERSONNEL BUREAU

Miss Elsie Dey, Director
332 Bulkley Building
Cleveland, Ohio

ADMINISTRATOR—Male nurse; B.S. Degree; experienced personnel supervisor and business consultant; 2 years assistant administrator, 125-bed hospital.

ADMINISTRATOR—Age, 32; M.H.A. Degree, 1954; 3 years finance officer, health clinics; 3 years assistant administrator, 700-bed eastern hospital.

ADMINISTRATOR — M.S. Degree, Hospital Administration, 1953; B.B.A. Degree, Accounting; 2 years comptroller; 2 years assistant administrator, 275-bed hospital.

HOUSEKEEPER—Age, 48; experienced businesswoman; 2 years training under director, housekeeping department, large eastern hospital; available.

PERSONNEL DIRECTOR—Degree; completed 15 months study in hospital personnel management, June 1957; will consider southwest.

PHARMACIST Chief—Age, 28; pharmacy resident, 1 year, teaching hospital, mid-west; 3 years experience.

(Continued on page 168)

INTERSTATE—*Continued*

PUBLIC RELATIONS DIRECTOR—B.A. Degree, 1948; 5 years sales promotion work; past 4 years experience, 300-bed hospital, central state; available.

POSITIONS OPEN

ADMINISTRATOR—Assistant; female R.N; in charge nursing service, nurse aide program, drugs & supplies; relief of administrator; suggest $400.00 salary but varying with qualifications; maintenance can be furnished; position open June 1, an interview desirable. Apply Administrator, Murphy Memorial Hospital, 1201 Highland Avenue, Red Oak, Iowa.

ADMINISTRATOR—Assistant; M.D. required; supervision and direction of professional services excluding nursing; direction of intern and resident program; experience in general hospital administration an asset; age 30-35 preferred; please state education, experience and salary desired. Apply Mr. Alex Smith, Acting Administrator, The Queen's Hospital, Box 614, Honolulu, Hawaii.

ADMINISTRATOR IN NURSING — Master's degree; experienced in nursing education and nursing service; 300-bed hospital school of nursing; salary open varying with qualifications. Apply MO 201, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

ANESTHETIST — Nurse; for 400-bed Joint Commission Accredited hospital; salary $460 per month, 40 hour week; opportunity for paid overtime work; many employee benefits. Apply Dr. R. Weyl, Anesthesiologist, Mount Sinai Hospital, Chicago 8, Illinois.

ANESTHETIST—Nurse; for 275-bed, university affiliated teaching hospital, located Chicago near-north side on Lake-front campus of Northwestern University; starting salary $420. month, 3 weeks paid vacation and 50% tuition reduction on courses at the university; $3,500,000 expansion program; modern, attractively furnished 1½ to 3½ room apartments rented at cost for single or married; most progressive benefit program in the field. Apply Personnel Relations Department, Passavant Memorial Hospital, 303 E. Superior Street, Chicago 11, Illinois.

ANESTHETISTS—Nurse; for 193-bed modern hospital located in a pleasant mid-western college city of 40,000; 3 weeks vacation and 10 day sick leave per year plus other liberal personnel policies; salary open. Write Personnel Office, Blessing Hospital, Quincy, Illinois.

ANESTHETIST—Registered nurse for obstetrics; salary open, three weeks vacation the first year, 12 days sick leave per year, accumulative. Apply to Personnel Director, Methodist Hospital, 1600 West 6th Avenue, Gary, Indiana.

ANESTHETIST—Nurse; 114-bed fairly new general hospital; salary open; usual perquisites; three in department, minimum of call backs. Write R. R. Hobart, Administrator, Coffeyville Memorial Hospital, Coffeyville, Kans.

ANESTHETIST — Nurse; male or female; 68-bed hospital, 100-bed hospital under construction; salary open. Apply Administrator, Gill Memorial Hospital, Steubenville, Ohio.

classified advertising

POSITIONS OPEN

ANESTHETIST—Nurse: position open in 134-bed general hospital; salary and living conditions very desirable; room, laundry and insurance benefits furnished in addition to salary; location on the east side of St. Paul with convenient transportation to the downtown area; two other anesthetists on duty with a minimum amount of call. Write E. M. Garnett, Superintendent, Mounds Park Hospital, 200 Earl Street, St. Paul 6, Minnesota.

ANESTHETIST — Nurse; female; excellent starting salary, merit increases, liberal fringe benefits, good hours; accredited hospital and surgeons limited to our staff. Apply to Elmer J. Berg, Business Manager, Gundersen Clinic, La Crosse, Wisconsin.

ANESTHETIST—Nurse; for 250-bed general hospital; excellent working conditions and personnel policies; good starting salary. Write Mr. Bert Stajich, Assistant Administrator, Columbia Hospital, 3321 N. Maryland Avenue, Milwaukee 11, Wisconsin.

ANESTHETISTS — Nurse; AANA members; $400-$475 per month; 400-bed general hospital, excellent working conditions, liberal personnel policies; T.O., 16 anesthetists and one anesthesiologist. Write Personnel Director, The Queen's Hospital, Honolulu, Hawaii.

ASSISTANT DIRECTOR — Medical records department; immediate opening; must be registered or eligible for registration; 446-bed general hospital; good salary and personnel policies; opportunity to work with professional activity study. Write Mr. J. M. Dunlop, Administrator, Bridgeport Hospital, Bridgeport, Connecticut.

ASSISTANT DIRECTOR OF EDUCATION—Experienced; need for diploma program; capacity 75 students; Master's degree preferred; salary $5500 to $7000, depending on experience and qualifications. Apply Director, St. Margaret's Hospital School of Nursing, 8th & Vermont, Kansas City, Kansas.

ASSISTANT DIRECTOR OF NURSES — To teach practical nursing students in a 250-bed geriatric home located in Chicago; Degree in nursing education required; salary depends on qualifications and experience; also interested in staff and supervisory nurses; excellent working conditions, 40-hour week with vacation, holidays, sick leave with pay and group insurance privileges; member of AHA. Call or write Director of Nursing, Orthodox Jewish Home For The Aged, 1648 So. Albany Avenue, Chicago 23, Illinois.

DIETITIAN—Chief: A challenging position; we are seeking an unusually competent person who has an excellent record in planning and directing a dietary department; this is one of the more progressive hospital organizations in the midwest, with a capacity of 315-beds; the facilites are new and modern, and salary is open and commensurate with ability and experience; submit a complete resume of age, education, experience and present salary. Apply MO 202, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

DIETITIANS—Therapeutic; large teaching hospital, 6 units affiliated with Washington University School of Medicine; monthly staff salaries begin at $300 based on a 40 hour week; due to the need for more professional dietetic hours in the medical center, dietitians are allowed overtime work and are paid at an hourly rate based on monthly salaries; two weeks vacation; social security; Blue Cross Apply, Director of Dietetics, Barnes Hospital, 600 South Kingshighway, St. Louis 10, Missouri.

DIETITIAN—Administrative; Borgess Hospital, 340-bed general hospital; full department head duties; a large full-time medical staff and house staff; salary open, progressive personnel policies. Apply Hospital Administrator, Borgess Hospital, Kalamazoo, Michigan.

DIETITIAN—Therapeutic; Borgess Hospital, 340-bed general hospital; duties include cafeteria, therapeutic diet planning, patient contact, general supervising and teaching student nurses; a large full-time medical staff and house staff; salary open, progressive personnel policies. Apply Hospital Administrator, Borgess Hospital, Kalamazoo, Michigan.

DIETITIAN—Assistant: preferably with therapeutic experience and considerable experience in personnel management; salary open; 40-hour week, liberal fringe benefits, position immediately available; hospital located in heart of beautiful Niagara County, New York—about 20 miles north of Buffalo and 18 miles east of Niagara Falls. For full information write Miss Betty Hall, Chief Dietitian, Lockport Memorial Hospital, Lockport, New Lork.

DIETITIAN—First assistant; new position; residential city near Cleveland; general hospital of 117-beds, expanding to 170-beds; beginning in 1958, further expansion of 150-beds on a separate site; residence available. Apply Lake County Memorial Hospital, Painesville, Ohio.

DIETITIAN — A.D.A., therapeutic; 160-bed general hospital, college town, 20 miles west of Milwaukee; major expansion program to be started in spring of 1957; modern dietary department completely remodeled in 1954-55. Apply Personnel Department, Waukesha Memorial Hospital, Waukesha, Wisconsin.

DIRECTOR OF NURSING EDUCATION—Man or woman; J.C.A.H. approved; 220-beds; B.S. in Education, Masters preferred; experience; liberal personnel policies; salary open with meals; diploma program; also nursing arts instructor, B.S. or working toward it. Write Director of Nursing, P.O. Box 529, Orangeburg, South Carolina.

DIRECTOR OF NURSING—Needed at once; 50-bed general hospital in Vermont; $450.00 a month; living accommodations available. Apply MO 200, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

DIRECTOR OF NURSES—132-bed JCAH approved general hospital and school of nursing; new school and dormitory facility is in planning stage; hospital was new in 1953; bachelor's degree required, master's desirable; salary commensurate with degree and experience; excellent personnel policies, social security and retirement program; attractive college town of 24,000 population. Apply Administrator, Passavant Memorial Area Hospital, Jacksonville, Illinois.

DIRECTOR OF NURSES—100-bed hospital now being enlarged to 180-beds; adequate training and experience required; salary open. Apply Administrator, Municipal Hospital, Virginia, Minnesota.

EDUCATIONAL DIRECTOR—Position open now; Master's degree preferred; Roman Catholic preferred; would like person with experience in the new type diploma or college degree programs; salary $4800 to $6000, depending on experience and qualification; midwest location. Apply MO 189, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

(Continued on page 170)

EDUCATIONAL DIRECTOR—Male or female; needed immediately; J.C.A.H. hospital, 130-beds, 25 bassinets, 60 students in temporarily accredited school of nursing; starting salary, $400.00. Apply MO 203, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

EDUCATIONAL DIRECTOR—For mid west general hospital; nursing school of 100 students; salary above average and will include complete maintenance, if desired, position open now or can report September 1; hospital will pay travel expenses of favorable applicant for interview. Reply to Medical Placement, 15 Peachtree Place, N.W., Atlanta, Georgia.

EDUCATIONAL DIRECTOR—Masters Degree and experience in teaching desirable; salary open, liberal personnel policies including 40 hour week, all cash salary, pension plan in addition to social security and hospitalization; living quarters available if desired; admit one class a year; three year diploma program; 300-bed hospital, 89 students; basic sciences taught at New Jersey Teacher's College; position open May 1957. Apply to Director of Nursing, The Mercer Hospital, Trenton, New Jersey.

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INSTRUCTOR—Obstetric nursing; in a fully accredited school of nursing; 170 students, 350-bed hospital in large metropolitan city with educational and cultural advantages; college affiliation; housing available; liberal personnel policies; salary open. Apply MO 180, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

INSTRUCTOR—Psychiatric nursing; B.S. Degree required; $3300 yearly salary; furnished apartment, meals and laundry, 40 hour, 5 day week, paid vacation, 7 holidays and liberal sick leave; approximate starting date April 15. Apply Personnel Office, Mental Health Institute, Independence, Iowa.

INSTRUCTOR—Clinical; in obstetrical nursing for both formal and clinical teaching; B.S. Degree and experience in teaching desirable; faculty being increased; liberal personnel policies; salary dependent upon qualifications and experience; admit one class a year, three year diploma program; 300-bed hospital, 89 students, position open for immediate appointment. Apply to Director of Nursing, The Mercer Hospital, Trenton 8, New Jersey.

INSTRUCTOR—Nursing Arts; B.S. Degree and experience in teaching desirable; salary dependent upon background and experience; liberal personnel policies; admit one class a year; three year diploma program; 300-bed hospital, 89 students; position open; have full time assistant instructor in this area. Apply to Director of Nursing, The Mercer Hospital, Trenton 8, New Jersey.

INSTRUCTOR—Biological science; B.S. Degree required; 220-bed general hospital; diploma program, social security and blue cross coverage, liberal personnel policies; salary open. Apply to Director of Nursing, P. O. Box 529, Orangeburg, South Carolina.

LIBRARIAN—Chief medical records-registered; 200-bed pediatric teaching hospital. Apply Administrator, St. Louis Children's Hospital, 500 S. Kingshighway, St. Louis, Missouri.

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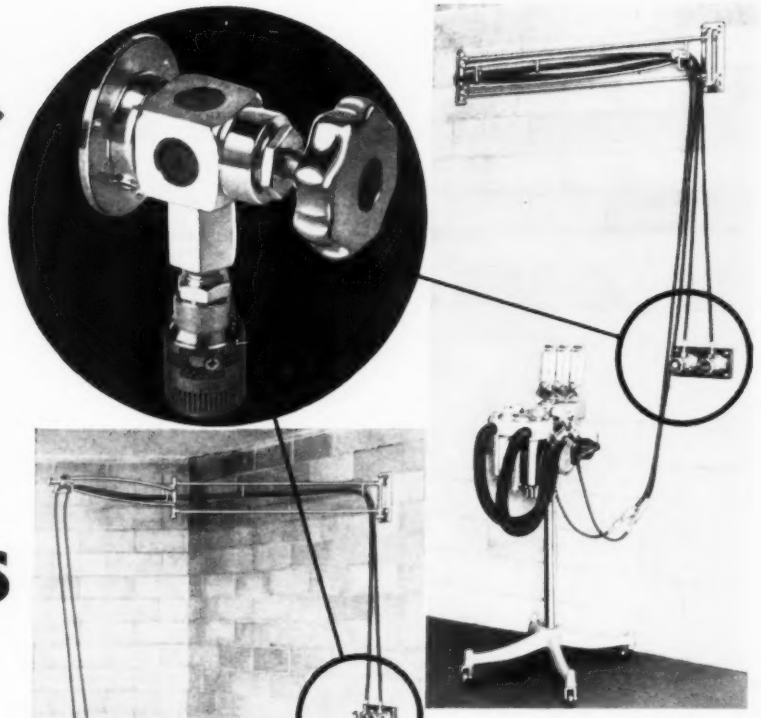

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NURSE—Registered; interested in teaching practical nursing; opportunities to develop own program; school not approved at present; desire individual capable of developing program which will meet State approval; small town located in southeast Pennsylvania. Apply MO 144, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

NURSES—Registered; for general duty; must have obstetrical experience; surgical experience desirable; salary $325.00 monthly for 40 hour week, with differential for evenings; 44 and 48 hour work available with commensurate pay; 2 week yearly vacation; sick time; new small hospital in mining town; low rental housing units, unfurnished; employment for husband usually available; excellent school; altitude 4000 feet. Write Administrator, Bagdad Hospital, Bagdad, Arizona.

NURSES—Registered; for modern psychiatric hospital in Greens Farms, Connecticut; 1 hour from New York; Hall-Brooke nurses have 8-hour duty, optional 5 or 6 days week, nicely furnished private rooms; excellent salary, 7 paid holidays annually, or equivalent; sick leave; vacation, minimum 2 weeks, maximum 4 weeks dependent on length of service; profit-sharing plan; psychiatric experience not necessary; registered or eligible in State of Connecticut. Apply Mary R. Walsh, R.N., Directress of Nursing, Hall-Brooke, Box 31, Greens Farms, Connecticut. Tel. Westport—Capital 7-5105.

NURSES — Registered; immediate openings; starting salary $240 month with opportunity for advancement; room, board and laundry annual vacation, liberal sick leave, 40 hour, 5 day week. Apply Personnel Office, Mental Health Institute, Independence, Iowa.

NURSES—Registered; Massachusetts General Hospital, Boston, Massachusetts; excellent clinical facilities, opportunity for advancement and attendance at local colleges; liberal personnel policies. Apply Personnel Department A-10 for further details.

NURSES—Registered; for 58-bed general hospital located in college town; openings on all shifts; 40 hour week; good salary program; liberal personnel policies, meals and laundry furnished. Apply Superintendent, Allen Memorial Hospital, Oberlin College, Oberlin, Ohio.

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NURSES—Registered general duty; for 28-bed general hospital; good salary and personnel policies; adjacent attractive residence; recreational facilities. For further particulars apply Superintendent, Niagara Hospital, Niagara-on-the-Lake, Ontario.

NURSES—Registered general duty; operating room and obstetrical departments; for 100-bed General Hospital located on the shore of Lake Erie; salary commensurate with experience and postgraduate training; good personnel policies. Apply Director of Nursing, General Hospital, Port Colborne, Ont.

NURSES—Staff; needed in new well equipped 100-bed hospital soon expanding to 200-beds in most desirable coastal city in southern California; 40 miles from Los Angeles, two hours from mountains. Write to Director of Nurses, Hoag Memorial Hospital-Presbyterian, 301 Newport Blvd., Newport Beach, Calif.

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NURSES—Staff; for new expanding hospital on Florida's west coast; salaries and personnel policies compare favorably with those in this area; 40-hour week, 4 weeks vacation, no shift rotation; Florida registration required. Apply Supervisor Nursing Service, Manatee Memorial Hospital, Brandenton, Florida.

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TECHNOLOGISTS—Medical; (2); modern expanding Cumberland Valley Hospital; fully approved; college town; 40 hour week, 10 days sick leave, social security, 2 weeks vacation, congenial relationships; maintenance if desired; automatic annual increments; start $3720 per year. Apply F. J. O'Brien, Administrator, Chambersburg Hospital, Chambersburg, Pennsylvania.

TECHNOLOGIST—Medical registered 160-bed general hospital, college town, 20 miles west of Milwaukee, major expansion program including new department of laboratory medicine to be started in spring of 1957; affiliation with Carroll College for training of medical technologists now in development stage; full time pathologist. Apply Personnel Department, Waukesha Memorial Hospital, 725 American Avenue, Waukesha, Wisconsin.

(Continued on page 172)

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ANESTHETISTS—(a) Well established anesthesia group; college town; midwest; to $8400. (b) Chief; four nurses, four physicians on staff; large general hospital; most ideal southern Florida resort city; $6000 up. (c) Staff; general hospital Hawaiian Islands, near Beaches; to $5700, transportation arrangement. (d) Two; 85-bed hospital; Great Northwest timber, salmon area; near leading university city; $7200 start. MH7-2

DIETITIANS—(a) Chief; 500 bed hospital; ability reorganize; cooperative staff; midwest; $6000 up. (b) Chief, 400-bed hospital; Greater Manhattan, New York, area; one month vacation; top salary. MH7-3

DIRECTORS OF NURSING—(a) Director of nursing, small hospital, Latin America; ability speak Spanish moderately; $6000, maintenance. (b) Director service and school; university affiliated 500-bed hospital with expansion program; near New York City; $10,000. (c) Director of nurses; brand new air conditioned hospital, 40-beds; Mexican Border; good salary. (d) Director nursing service; reorganization expansion program; outstanding opportunity for capable executive nurse, $7000; San Francisco area. MH7-4

EXECUTIVE HOUSEKEEPERS—(a) Male or female, 200-bed new hospital, college town, south; $5400. (b) Small coed college; supervise staff; maintenance student resident halls; pleasant working and living conditions, midwest. MH7-5

EXECUTIVE PERSONNEL—(a) Business manager with strong background in accounting; 400-bed hospital; affiliated medical school; midwest. (b) Comptroller; 200-bed hospital; resort and college town, west. (c) Executive secretary; medical society; university city, west. (d) Personnel director; university hospital, 300-beds, midwest. (e) Public relations director to serve as personnel director also; 200-bed hospital; minimum $6000; New England. (f) Food service director; newly created position; 600-beds; east. (g) Laundry manager; 450-bed hospital near New York City. MH7-6

MEDICAL BUREAU—*Continued*

FACULTY POSTS—(a) Medical-surgical instructor; new four year college program; West Mountains; $455 month academic year. (b) Pediatric, medical-surgical, collegiate school; teaching only; Northern California; $5100-$7600. (c) Chairman, nursing education program, State college; $8000. (d) Psychiatric, public health, pediatric instructors; faculty status; $6000-$7200; southwest. MH7-7

MEDICAL RECORD LIBRARIANS—(a) Director-instructor; school for medical records librarians; outstanding opportunity; progressive city; southwest. (b) Chief; new position; reorganization of ocean city hospital; wealthy California community; salary commensurate ability. MH7-8

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SUPERVISORS—(a) Psychiatric in-service for professional nurses, P. N., aides; establish program; $5000; Near Washington, D.C. (b) EENT and psychiatric; 900-bed hospital, university center; $5200-$5500; midwest. (c) Operating room, pediatric; 450-bed hospital, leading manufacturing city, near Lake Michigan summer resort, $5000. (d) Operating room supervisor, capable assuming direction nursing service; excellent opportunity; 40-bed new air-conditioned hospital, Texas; $5000. MH7-10

ADMINISTRATORS—(a) Medical director with administrative experience and executive ability; 565-bed hospital, JCAH, for interns and residents; $12-15,000; college town; east. (b) 500-bed hospital expanding to 700; emphasis on fiscal affairs; work under hospital director, have full supervision over several employees; requires administrative experience and education equal to college degree; midwest. (c) 75-bed general hospital; provisional approval; about $7,000; south. (d) Superintendent; 350-bed hospital, training school; industrial center; midwest. (e) One with at least 10 years experience as hospital administrator, would like FACHA for newly proposed hospital in California.

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(Continued on page 174)

INTERSTATE—*Continued*

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CONTROLLER—(a) 175-bed hospital, Ohio. (b) 130-bed hospital, Pennsylvania. (c) Office Manager; Ohio.

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ASSISTANT ADMINISTRATORS—(a) 220-bed hospital; college MSHA Degree required plus 5 years experience; to take hospital over in one year; salary open. (b) 300-bed hospital; east; MSHA Degree required; salary open. (c) 350-bed hospital; midwest; Degree plus experience in personnel and public relations; salary $8,500.

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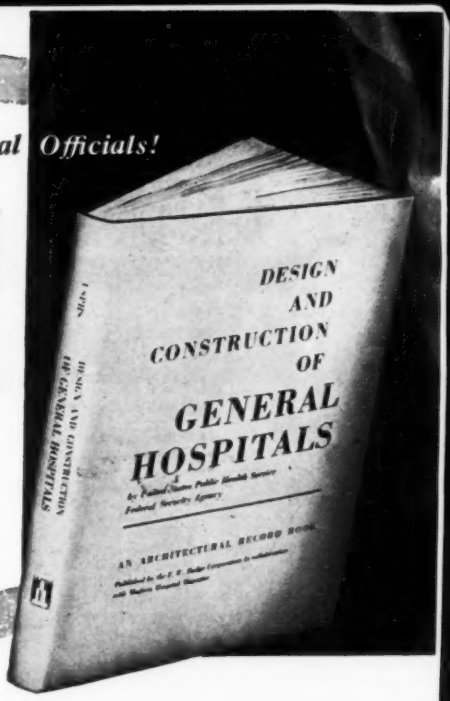

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SCHOOL FOR LABORATORY TECHNICIANS—Duration of course, 1 year. Tuition, $100.00; approved by the American Medical Association. For further information, write the Director of Laboratories, Barnes Hospital, 600 S. Kingshighway, St. Louis, Missouri.

(Continued on page 176)

The CHICAGO LYING-IN HOSPITAL AND DISPENSARY of the University of Chicago offers a six-months course in OBSTETRIC NURSING to qualified graduate nurses. The course includes all phases of maternity nursing. The student may elect experience in one special area for two months of the course. Modern, attractively appointed kitchenette apartments are provided. Adequate allowance is made for food and laundry. For further information, write to the Director of Nursing, 5841 Maryland Avenue, Chicago 37, Illinois.

The BOSTON LYING-IN HOSPITAL offers to qualified registered nurses a six-months internship in maternity nursing. Clinical experience is offered in all phases. This includes antepartal clinics, delivery room, postpartum and diabetic unit, normal newborn, and premature nursery. Each nurse intern will have the opportunity to deliver a mother under supervision. An elective period will be spent in advanced experience in the area of choice. Room, laundry, food allowance and a stipend of $75 per month is granted. Rooms are provided in a graduated house. The registration fee is $20. For complete information write to Carolyn Davies R.N., Director of Nurses, Boston Lying-in Hospital, Boston, Massachusetts.

GRADUATE HOSPITAL OF THE UNIVERSITY OF PENNSYLVANIA offers a four month course in operating room technic and management to registered graduates of accredited schools of nursing. Registration fee $20.00. Full maintenance and $30.00 monthly cash allowance given. Apply to Director of Nursing Service, 1818 Lombard Street, Philadelphia 46, Pennsylvania.

The PROVIDENCE LYING-IN HOSPITAL offers to qualified graduate nurses a four months supplementary clinical course in Obstetrics. Full maintenance and stipend of $75.00 a month is provided. For full information, apply to the Director of Nurses, Providence Lying-In Hospital, Providence 8, Rhode Island.

UNIVERSITY OF MICHIGAN School for Nurse Anesthetists offers a 16 month course for nurses interested in anesthesia. Accredited by the American Association of Nurse Anesthetists. The training includes all techniques in inhalation, intravenous, and rectal anesthesia. Unlimited opportunities for endotrachael intubation and open chest anesthesia. Stipend provided. For information write, School for Nurse Anesthetists, University Hospital, Ann Arbor, Michigan.

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NOW AVAILABLE! THE FIRST STERILE STAINLESS-STEEL BLADE

New SteriSharps® can be autoclaved! Eliminate messy solutions...blade waste!

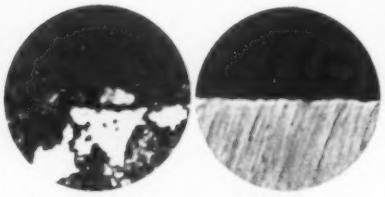
PHOTO COURTESY WILMOT CASTLE CO.

New stainless-steel SteriSharps — sharpest blades made — come individually sealed in foil, ultrasonically cleaned, ready for instant use. Save time, simplify technic in the OR.

SteriSharps are used only as needed — do away with the wasteful practice of preparing several blades for each operation. And SteriSharps can be autoclaved, just like other instruments so as to be instantly available to the suture nurse. Sealed packets can be re-autoclaved, stored indefinitely. Will not corrode.

Your supplier has SteriSharps in every design. And a stainless-steel dispenser is yours free with every five gross. Or write: A·S·R Hospital Division, Dept. MH, 380 Madison Avenue, New York 17, New York.

AUTOCLAVE TEST PROVES STERISHARPS SUPERIORITY



ORDINARY BLADE STERISHARP

One of a series of tests which demonstrated the superiority of SteriSharps in hospital use subjected a SteriSharp and an ordinary surgical blade to autoclaving—under 18 pounds of pressure at 250° F.—for 30 minutes. The ordinary blade (left) was severely corroded and stained, and the edge became rough and impaired. The SteriSharp (right) did not corrode. The cutting edge was unaffected. Actual photos shown are magnified 1,000 times.

A·S·R precision products

SteriSharps . . . the first sterile, stainless-steel surgical blade

TO HELP YOU get more information quickly on the new products described in this section, we have provided the convenient Readers Service Form opposite page 192. Check the numbers on the card which correspond with the numbers at the close of each descriptive item in which you are interested. The MODERN HOSPITAL will send your requests to the manufacturers. If you wish other product information, just write us and we shall make every effort to supply it.

Patient-Ready Dressing Is Non-Adhering

Steripak Non-Adhering Dressing is a new post-operative absorbent dressing

ready for use on the patient. The complete dressing comes individually wrapped and sterile. Steripak contains a non-adhering, perforated plastic film covering an absorbent pad which is secured to vented plastic Johnson & Johnson Super-Stick adhesive tape. It is perforated to permit maximum aeration. The dressing can be quickly applied, can be readily tailored to fit individual wounds and is neat and sturdy. Light to medium drainage is immediately absorbed and the absorbent pad will not adhere to the wound. Steripak is designed for use for hernias, appendectomies, hysterectomies, lumbar sympathectomies and other flat surface, light drainage incisions. It is constructed to support the suture line firmly with closure effect.

Designed to move from the storeroom to the patient floor, Steripak eliminates handling, counting, wrapping and even autoclaving since sterility is assured unless the paper wrapping is punctured. Steripak is available in two sizes: four by four and four by eight inches, packed in disposable tray dispensers. Its use permits allocation of precise costs to each patient. **Johnson & Johnson, New Brunswick, N.J.**

For more details circle #801 on mailing card.

Special Printer for Sealing Tape

Flat back pressure sensitive tape can be printed with the new Weck tape printer. When the tape is used to seal packages for autoclaving, Weck Autoclave printing ink, which prints red but changes to green when autoclaved, can be used. Three jobs are accomplished at once with the printed tape which seals the package, identifies the contents and indicates, by the color of the ink, whether or not the package has been autoclaved. The tape printer with any desired label as well as the Autoclave Ink and the tape make up a complete service. **Edward Weck & Company, Inc., 135 Johnson St., Brooklyn 1, N.Y.**

For more details circle #802 on mailing card.

Ultrasonic Unit for Therapeutic Use

The new Model UM-600 Ultrasonic Therapy Unit utilizes ultrasonic energy for the treatment of arthritis, bursitis, osteoarthritis and other related ailments. It provides an accurately calibrated sound wave frequency of one million cycles per second and dosage intensity up to three watts per square centimeter is easily regulated by a single knob.

The machine shuts off automatically at the end of a designated treatment period by a timer switch. A power control reg-

ulator holds power output constant regardless of line voltage variation. The unit operates on 60 cycle 115 volt A.C. or on D.C. with a rotary converter. **American Cystoscope Makers, Inc., 1241 Lafayette Ave., New York 59.**

For more details circle #803 on mailing card.

Keysort Data Punch for Nursing Stations

The processing of Keysort Requisition Charge Tickets at nursing stations can be facilitated through use of the new Keysort Data Punch. The new machine punches Keysort Cards and imprints data on the card face in a simultaneous action. Such information as nursing station identification, patient's name, class of payment and other pertinent facts are imprinted by the Data Punch while punching the data into the Keysort Card.

Changes in procedure can be effected without briefing of operating or processing personnel through preparation of new Data Punch Plates, putting the new procedure immediately into effect. The compact, non-electrical machine can be located at points of greatest use. **Royal McBee Corp., Data Processing Division, Smith St., Athens, Ohio.**

For more details circle #804 on mailing card.

(Continued on page 180)

Anti-Slip Wax for All Floor Surfaces

Westwax, a water emulsion wax for use on all floor surfaces, has a completely new formula. The anti-slip wax is formulated with a highly refined grade of pure, light-colored Carnauba wax, permitting its use on light colored or even white floors without fear of discoloration. The wax contains Mirite, a hard, clear, glossy plastic emulsion for extra durability, developed by the manufacturer, and Ludox, for increased anti-slip properties. The new Westwax provides a high initial gloss without buffing, is scuff-resistant and water resistant, yet is easily removed when desired. **West Disinfecting Co., 42-16 West St., Long Island City 1, N.Y.**

For more details circle #805 on mailing card.

Surgeons' Gloves Available in Hospital Pack

All Matex and Massillon Latex surgeons' gloves are now available in a newly- designed hospital pack. The new pack saves one-half the shelf space needed to store gloves and eliminates the time and bother of getting rid of small cartons and tissue packing. Weight is also reduced by 25 per cent. The hospital pack holds 24 transparent bags, each containing one dozen pairs of gloves of a size. As illustrated, the hospital pack

on the right hand shelf holds as many gloves as the cartons on two shelves at the left. **Massillon Rubber Company, Massillon, Ohio.**

For more details circle #806 on mailing card.

WHAT'S NEW

No. 1213 Gift Truck Has Large Carrying Capacity

A large sized gift truck with three large shelves and four storage drawers

is available in the No. 1213. Maximum visibility of merchandise is provided in the design of the truck which has large carrying capacity, yet moves easily and quietly when loaded. Six casters in the running gear assure easy mobility.

Shelves are fabricated of 20-gauge steel with 1½ inch turned up edges. The bottom shelf is 23¾ by 45¾ inches in size and the inverted V-shaped center shelf has sides pitched sufficiently for good visibility of displayed articles. Two display levels on either side are provided on the top shelf. The sturdily constructed truck is 26¼ inches wide, 55 inches overall length and 46 inches overall height on six-inch casters. The No. 1213 is available in baked enamel finish in Cheery Cherry Red, Holland Blue, Nile Green, Radio Grey and Brewster Green. **Jarvis & Jarvis, Inc., Palmer, Mass.**

For more details circle #807 on mailing card.

Hamper Bags Meet All Institutional Needs

The new Nethcraft Hamper Bags are offered in both 18 and 25-inch sizes which fit round, square, triangular and collapsible hampers to fill almost any hospital need for a sturdy, longwearing hamper bag. Nethcraft Hamper Bags are made of Sail Boat Drill quality 100 per cent cotton for heavy duty use. Other

construction features include sturdy No. 6 sash cord, heavy bar tack and double needle stitching. **The Art Neth Company, 400 Deming Place, Chicago 14.**

For more details circle #808 on mailing card.

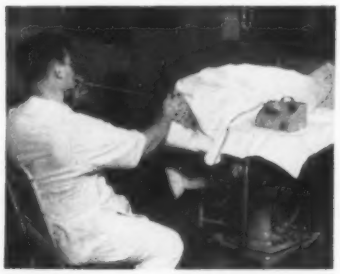
Tubular Steel Mop Handles Have Plastic Grip

Warping, splintering and slivers are eliminated with the new tubular steel mop handle added to the Geerpres floor cleaning equipment line. The baked-red enamel finish resists scratching and rusting and the plastic handle grip assures positive mop control. The mop holder is electroplated and corrosion resistant. The new Tangleproof metal mop handles are available in standard lengths of 54 and 60 inches. **Geerpres Wringer, Inc., P. O. Box 658, Muskegon, Mich**

For more details circle #809 on mailing card.

Voltage Source for Diagnostic Light Instruments

The Anthony Battery Eliminator is a new variable voltage source for diagnostic light instruments. Voltage may be varied from 0 to six volts with a maximum of two amperes capacity. Setting and monitoring of voltage levels is accomplished by a voltmeter. New signal circuits in the model indicate open circuit or short circuit conditions. A specially designed transformer with a high insulating rating and hermetically sealed



to prevent entrance of moisture supplies the low voltage. The instrument is constantly ready for use, requiring no recharging, refilling or other attention. A resettable current breaker ensures maximum safety. The small, lightweight unit operates on 110 volts A.C., 60 cycles, **Anthony Associates, 63 Harbor Lane, Massapequa Park, N.Y.**

For more details circle #810 on mailing card.

Steam Boilers Are Fully Automatic

Two new high pressure steam boilers have been introduced by Cyclotherm. The new units with capacities of 50 and 60 h.p. respectively, are fully automatic for unattended operation. The boilers, with only 98 square feet of heating surface, burn No. 4 oil, light oil, gas or a combination oil and gas. All boiler trim, as well as burner, outlets, motors and other parts are furnished and only five connections are necessary for installation. **Cyclotherm Div., National-U. S. Radiator Corp., Oswego, N.Y.**

For more details circle #811 on mailing card.

(Continued on page 182)

WHAT'S NEW

Easy-Cleaning Pivot Sash Now Available in Aluminum

The dependable Williams Pivot Sash, which permits the cleaning of windows from the inside of a room at floor level, is now available in aluminum. This is in addition to the original wood window, in use in hospitals, schools and other institutions for the past fifty years. The aluminum version was developed to satisfy the demand for the pivot sash window in metal since the pivoting feature facilitates ventilation and permits savings in time and insurance rates in window cleaning. The new window can have various muntin arrangements and may be fitted into prepared openings in new buildings, or may replace windows in older hospitals.

Fabricated of aluminum extruded sections by Kesko Products, custom fabricators of monumental windows, the new version is available in brushed satin, satin Alumilite or caustic etch finish. The window is completely weather sealed. For ventilation purposes it incorporates

all the advantages of a double hung window with each light of the sash pivoting independently. It is offered with a lever type cam lock but is also furnished with a key type lock for installations where unauthorized personnel or patients should not open the windows. Wire screens or detention screens may be used with the windows which may be single glazed or glazed with double insulating glass. **The Williams Pivot Sash Co., 1827 E. 37th St., Cleveland 14, Ohio.**

For more details circle #812 on mailing card.

Drapery Fabric for Pediatric Unit

A new drapery pattern designed to appeal to young children is introduced with the descriptive name of "Child's Play." The pattern consists of several stick figures in various play positions familiar to all children and should be attractive for use in pediatric departments. It is available in several color arrangements and is printed on Infinity Rayon backed linen, a sturdy fabric with the lining woven right into the patterned fabric. **Edwin Raphael Co., Inc., Holland, Mich.**

For more details circle #813 on mailing card.

Cold Compartment Has Variable Tray Capacity

The cold compartment in the new Blickman Foodveyor converts from 18

to 20 to 22 or 24-tray capacity by means of a quick change of tray slide racks. The unit is equipped with four-inch spaced non-tilt tray slides which accommodate 18 trays. When needs change, the racks are removed and replaced with smaller spaced racks to accommodate up to 24 trays spaced three inches apart. The cold compartment is cooled by an instantaneous blower-cooling system powered by a ¼ h.p. compressor and temperatures can be regulated down to approximately 40 degrees F.

The heated compartment of the Model CS-1218 RB has eight drawers which hold three nine-inch plates and three bouillon cups each. It is fully insulated and is thermostatically controlled to keep foods piping hot. **S. Blickman, Inc., Weehawken, N.J.**

For more details circle #814 on mailing card.

18 Unloading Models Added to Troy Washer Line

The line of Troy laundry washers has been expanded by the addition of 18 unloading models. The machines are now available in dry weight capacities from 225 to 400 pounds, with 42-inch cylinders from 54 to 96 inches in length. Each can be supplied with fully automatic, semi-automatic controls on operation and addition of supplies.

The new unloading models feature separate motor for cylinder lift and drive,

heavy cross members at rear of frame, an unusual take-up feature on the drive mechanism and electrical interlocks for complete safety of operation. **Troy Laundry Machinery Division, American Machine & Metals, Inc., East Moline, Ill.**

For more details circle #815 on mailing card.

(Continued on page 184)

WHAT'S NEW

Isolette Rocker for Asphyxiated Newborn

The new Isolette Rocker is designed to help restore and maintain circulation and

breathing in asphyxiated premature or full-term infants. The rocker fits inside the Isolette infant incubators without alterations or adjustments and allows the apneic infant to be gently rocked while surrounded by optimal conditions of temperature, humidity and isolation.

The Isolette Rocker is pneumatically operated with compressed air or oxygen and provides any angle of rocking up to 20 degrees above and below horizontal at rates up to 20 rocks per minute. The infant is comfortably secured to the rocker by means of a special diaper fastened at each side and at the foot, and shoulders are gently held in place by adjustable foam-rubber cushions. A positioning rod holds the rocker at rest and permits horizontal or Trendelenburg position of bassinet. **Air-Shields, Inc., Hatboro, Pa.**

For more details circle #816 on mailing card.

Snap Fasteners Hold Diapers

Dot snap fasteners are used to fasten the new Quickee Diaper-Panty quickly and easily. Pins and danger of injury to nurse or infant from sticking are eliminated. The diaper is tailored to fit snugly on infants from birth to 18 months and is adjustable to six different positions on each side to accommodate comfortably to the needed size. The fabric-flat Dot Snappers are fitted on front and overlapping flaps on the back to eliminate bulk. A special feature of the diaper is the knitted cotton band material at the leg openings for added comfort and absorbency.

Quickee diapers are made from top quality Red Star "Birdseye" diaper cloth in four-ply thickness. An open end "pocket" permits the insertion of extra material for added absorbency when needed. The diapers may be washed and sterilized and the Dot Snappers are said to last the life of the cloth. **Quickee Diaper Panty Corp., 1350 Broadway, New York 18.**

For more details circle #817 on mailing card.

(Continued on page 186)

Portable Respirator Is Compact and Lightweight

Light weight and portability are features of the new Monaghan Respirator recently introduced. Cased in anodized aluminum, the unit weighs only 29 pounds and operates on regular current and also operates on a 12-volt battery. The battery is recharged when plugged into regular current and will operate the unit up to four hours. For transferring patients, the respirator can be operated in an automobile by plugging it into the cigarette lighter.

The unit is equipped with A.C. and D.C. Manual Reset Circuit Breakers, a battery-operated signal alarm, and operates at a respirator rate of 10 to 40

per minute. A hand bellows for emergency manual use is part of the unit. **J. J. Monaghan Company, 590 Alcott St., Denver 4, Colo.**

For more details circle #818 on mailing card.

WHAT'S NEW

Identification System for Mothers and Babies

The new "Double Ceremony" identification system for mothers and babies is designed to meet all the recommendations made by the American Hospital Association for this type of identification. The set consists of a 10½-inch strap, long enough to provide a bracelet for the mother and two bracelets, or one bracelet and one anklet for the infant, three name plates, three cards and a supply of rosettes.

The straps are made of strong, soft plastic in blue, pink and white. It is non-irritating, non-toxic and attractive in appearance. Straps are adjustable to fit the patient and are fastened quickly and easily to the name plates. **The Presco Company, Inc., Hendersonville, N.C.**

For more details circle #819 on mailing card.

Built-In Wardrobe Unit Saves Space in Dormitory

A complete built-in unit for dormitories and nurses' homes is now available in the Woodridge wood and steel furniture line. The modern space-saver includes two wardrobes, three overhead cabinets and a six-drawer dresser and mirror in one built-in unit which is quickly and easily installed. Modern in design and construction, the unit is 95½ inches high, making a full floor-to-

ceiling built-in for rooms with eight-foot ceilings. All units are 24½ inches deep and wardrobes and cabinets are available in 30, 36 and 40-inch widths.

The Woodridge line is made of wood and metal, combining the beauty of wood with the strength of steel. Steel is used for the inner frames and the individually removable wood panels are available in Frosty Walnut or Imported Birch. Tops are of easily maintained plastic. Finger-grooved drawers eliminate the need for hardware although units with hardware are also available. Other items in the Woodridge line include single and double dressers, desks, nightstands and beds. Pieces may be mixed and matched with the built-in or individual units. **Royal Metal Mfg. Co., 175 N. Michigan Ave., Chicago 1.**

For more details circle #820 on mailing card.

Enzymatic Greaseptor Flushes Grease Away

The new Enzymatic Greaseptor is a self-cleaning automatic grease interceptor. A specially-prepared enzyme concentrate called "Blue Label Enzymatic," is poured through a treatment port in the cover of the new Greaseptor. By biochemical reaction the accumulated grease is converted into water-soluble compounds that automatically flush away into the drainage system. The chemical action eliminates possibility of damage to plumbing.

The result of six years of research and testing, the new lipase-oxidase-type enzyme used with the new Greaseptor helps to keep plumbing lines clean and clear. The new Enzymatic Greaseptor requires no special installation and minimum maintenance. **J. A. Zurn Mfg. Div., Zurn Industries, Inc., Erie, Pa.**

For more details circle #821 on mailing card.

WHAT'S NEW

Air Control Unit Features High Velocity

The Model CM High Velocity Control Unit is a practical means of air distribution where space requirements necessitate high velocity air to be delivered to the individual diffusers. It is designed for both new and existing buildings for installation under windows or on any wall surface. The front of the cabinet

is sloped to prevent the grille from being covered by objects which might prevent proper air distribution. **Barber-Colman Co., Dept., 766, Rockford, Ill.**

For more details circle #822 on mailing card.

Single Tank Dishwasher Has Power Wash

The Universal SE Economy Model Dishwasher features a newly designed power wash with jet nozzles which revolve above and below the dishes for complete washing and rinsing. The single tank semi-automatic door type machine handles 19¾ by 19¾ inch racks. It has three doors, two operating simultaneously for easy access or for positioning in either straight through or corner operation. **Universal Dishwashing Machinery Co., Nutley 10, N.J.**

For more details circle #823 on mailing card.

Interior Door Resists Abuse

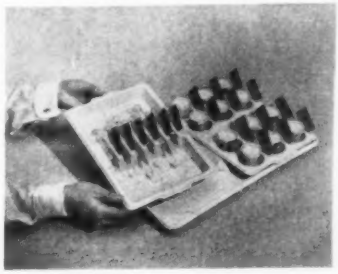
The Weldwood Custom Royal Door for interior use is surfaced with Micarta to withstand the hard wear of institutional use. This sturdy plastic surface, which is not easily damaged or marred, requires no push-plates or kick-plates, is immune to stains and won't chip, splinter or corrode. It needs no waxing or staining and fingerprints, dust or grease are easily removed.

The Micarta surface is bonded to standard Weldwood Stay-Strate solid core, staved lumber core and hollow core doors in many styles. Custom Royal doors come in four Trugrain faces of mahogany, oak, maple and walnut. **U.S. Plywood Corp., 55 W. 44th St., New York 36.**

For more details circle #824 on mailing card.

Plastic Tray Set Holds Medicines and Cards

The new Tomac three-piece tray set has been designed to keep medication



and syringes together with patient medicine cards for easy identification and quick administration. Medicine cards stand in slots adjacent to each medication cup on the oral medicine tray. The syringe tray is grooved to hold six 2 cc., 5 cc. or 10 cc. syringes firmly by their collar and also has adjacent slots for placement of medicine cards. The large tray is designed for dressings, juices or water glasses. The set is made of white styrene plastic, will fit any cart and has molded handles for firm grip. It may be washed or cold sterilized. **American Hospital Supply Corp., 2020 Ridge Ave., Evanston, Ill.**

For more details circle #825 on mailing card.

(Continued on page 188)

WHAT'S NEW

Mobile Food File Rack for Vimco Refrigerators

The Vimco Series "V" Refrigerators are equipped with a full length mobile

food file rack for bulk unit loading, unloading and handling of foods. The loaded rack can be placed in or taken out of the refrigerators with ease by a specially designed cart. The result of two years of research and experimentation, the new unit will hold as many as 126 twelve by twenty by two-inch deep pans and will also take other pans of full or fractional sizes.

Vimco Series "V" refrigerator doors are full length to house the new unit, eliminating loss of space due to cross mullions, back wall or ceiling type refrigeration coils. The mobile unit will incorporate the Vimco, Sta-Kold and Sno-Queen patented interchangeable features accommodating regular or pull-out shelves. **Victory Metal Mfg. Corp., Plymouth Meeting, Pa.**

For more details circle #826 on mailing card.

Counter-Top Head for Standard Premix Units

The new QuiKold Counter-Top Dispensing Head has been designed for use with any standard premix equipment found in cafeterias, lunchrooms and other locations. Made of stainless steel for attractive appearance and easy maintenance, the QuiKold Head is available with one, two or three faucets.

A fluorescent-lighted plastic panel on the front of the head carries the trademark inset. The unit has plastic dispensing draft arms, counter-top fastening brackets and drip pan with nipple

for attaching to drip container hose. Overall width of the dispensing head is 13⅛ inches. **S & S Products, Inc. P. O. Box 1047, Lima, Ohio.**

For more details circle #827 on mailing card.

Albutest Reagent Tablets for Quick Albumin Test

The presence of proteinuria can be quickly detected by the use of the new colorimetric tablet test, Albutest. A color change on the surface of the tablet to which a drop of urine has been added indicates the presence of protein. The intensity of the color is in proportion to the amount of protein present. No color change is noted when the urine is negative. Color photographs supplied with the tablets serve as a guide to reading results. Albutest is supplied in bottles of 100 and 500 reagent tablets. **Ames Company, Inc., Elkhart, Ind.**

For more details circle #828 on mailing card.

Mobile X-Ray Unit Has Electronic Exposure Timer

The new G.E. Mobile "90" X-Ray unit features a special electronic circuit which permits split-second timing of the x-ray exposure to minimize the inconsistencies in exposures and images often found with mobile units. The device offers up to 90 kilovolts at 15 milliamperes to permit the use of a 1.5 mm effective focal spot which also increases image detail and sharpness on the x-ray film.

The unit is equipped with large, ball-bearing, rubber-tired wheels for ease in moving from place to place and a 20-

inch extension of the tube-arm makes it easy to extend the tube head over the bedside. **General Electric Co., X-Ray Dept., Milwaukee 1, Wis.**

For more details circle #829 on mailing card.

Wood Grain Wall Panel for Interior Walls

The new Masonite Seadrift decorator Wall Panel has a wood grain pattern embossed into the surface of durable ¼ inch Tempered Presdwood. It can be easily nailed, screwed, jointed, planed, beveled, sanded and sawed and will not split, splinter or crack. Seadrift is available in panels four feet wide and up to 16 feet long which may be finished in a single tone or two-tone paint, enamel or lacquer. **Masonite Corp., 111 W. Washington St., Chicago 2.**

For more details circle #830 on mailing crad.

WHAT'S NEW

Reenforced Cylinders for Silver Handling System

Two new cylinders, doubly reenforced at the bottom, are now available for use in the Steril-Sil silver handling system. The cylinders are molded of durable DuPont Zytel gray nylon, about the color of stainless steel utensils, and the same material used for bearings, gears and bushings in the Steril-Sil washing units.

The nylon cylinders are designed for heavy duty use without distortion or damage. They are quiet, lightweight, easy to handle, rigid and sturdy. The nylon is not affected by temperatures up to 300 degrees F. and is impervious to

normal acids and alkalies. It will not scratch or dull the utensils and cools almost immediately when taken from the sterilizer. Silverware is washed in the injector type washers, eating portions up, then tumbled into empty sterile cylinders, eating portions down, for service, thus protecting the sanitary, sterilized ends until ready for use. Baskets and dispensers are available in different sizes to fit every requirement. **The Steril-Sil Co., 150 Causeway St., Boston 14, Mass.**

For more details circle #831 on mailing card.

Ribbon Glass Windows Have Ceramic Colors

Vitrolux is the name given to a new spandrel glass for modern wall structures. It has ceramic colors fused onto the inner side of the plates in a selection of sixteen standard colors and black and white. The quarter-inch plate glass is heat-strengthened for added strength to resist shock and is available in maximum size of 60 by 84 inches. The new polished colored plate glass surfacing material will hide building service facilities and structural framework while providing color contrasts in entire walls of glass.

A new Blue Ridge spandrel glass product recently introduced by Libbey-Owens-Ford is known as Huetex. This patterned texture glass provides a colored surface to contrast with the polished ribbon window of plate glass now available in colors in Vitrolux. **Libbey-Owens-Ford Glass Co., 608 Madison Ave., Toledo 3, Ohio.**

For more details circle #832 on mailing card.

(Continued on page 190)

Ace-Hesive Elastic Bandage Minimizes Skin Irritation

The new B-D Ace-Hesive elastic bandage incorporates the purest available

grades of resin and rubber together with a highly volatile solvent to minimize the possibility of skin reactions to the ingredients. Ace-Hesive will not slip or creep and ensures uniform pressure and ease of application and removal.

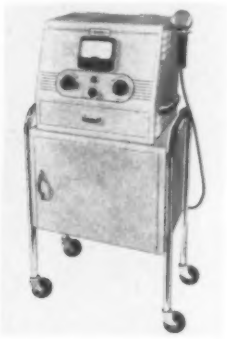
Ace-Hesive is available in four widths, two, two and one-half, three and four inches, and extends approximately three yards unstretched. It is packaged in a regular pack of a single bandage or in a waxed sealed tube containing bandages totaling 12 inches in width. **Becton, Dickinson and Co., Rutherford, N.J.**

For more details circle #833 on mailing card.

WHAT'S NEW

Ultrasonic Generator Is Hermetically Sealed

The new Dakon Model UTG-1 Ultrasonic Generator is the product of several



years of research, testing and development. The entire assembly of the precision-engineered instrument is hermetically sealed for use in underwater treatment. Features of the instrument include a precision frequency-stabilized oscillator which is described as being unaffected by time or severe usage. Parts are treated to give top service with minimum maintenance or repair, according to the manufacturer.

A new sensing circuit automatically cuts off power to the transducer if it should become accidentally damaged. This circuit also energizes an audible signal to the operator that contact is insufficient for adequate therapy. The new unit complies with all FCC requirements as to minimum conducted line and radiation interference, according to the report. It is available in ivory, green or salmon finishes. **Dakon Tool & Machine Co., Inc., 1836 Gilford Ave., New Hyde Park, L.I., N.Y.**

For more details circle #834 on mailing card.

Caster Lock Has Kick Release Bar

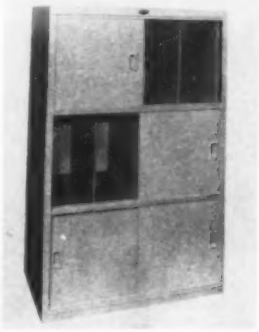
A kick release bar is now standard equipment on the Bassick F410 Position Lock for casters on trucks, scaffolds and other mobile equipment. The shoe is set securely in contact with the floor by an easy downward pressure on the pedal and a downward pressure on the kick bar easily releases the lock. Locking pressure can be controlled to ensure secure holding, even on uneven floors. **The Bassick Co., 3045 Fairfield Ave., Bridgeport 5, Conn.**

For more details circle #835 on mailing card.

X-Ray Negatives Filed in Compact Storage Unit

X-ray negatives up to 14 by 17 inches in size are easily filed in minimum space with the new Bentson Vert-X-File, Series 1600 and 1601. The sturdily constructed units have the exclusive Bentson rod construction, providing maximum strength in minimum space. The full contents of each compartment are made quickly accessible through sliding doors. A handy label holder on each compartment provides for quick identification of the contents.

Available in two, three and five-shelf units in the 1600 series, Vert-X-Files require no maintenance other than occasional cleaning. They are finished in Dur-O-cote enamel. The 1601 series features flexibility of stacking units which are especially suited to expanding depart-



ments. Shur-Loc fasteners secure the stacking units which interlock to form a solid file. **The Bentson Mfg. Co., Highland Ave., Aurora, Ill.**

For more details circle #836 on mailing card.

WHAT'S NEW

Toilet Compartments in Vitre-Steel

Henry Weis Toilet Compartments are now available in Vitre-Steel, the trade name given to this application of por-

celain enamel on steel. The compartments are available in both ceiling hung and floor braced styles. Vitre-Steel withstands everyday usage and is resistant to acids, cleaning compounds and even defacement, making it an ideal material for toilet compartments. **Henry Weis Mfg. Co., Inc., Elkhart, Ind.**

For more details circle #837 on mailing card.

Multi-Purpose Bronchoscope Effective in All Five Lobes

Designed for A. Albert Carabelli, M.D., the new Pentascope is a multi-purpose bronchoscope for procedures in all five lobes of the lung. It consists of a tube, light carrier and sheath, deflector and operating channel insert and accessory collars and adapters.

The Pentascope can be used for examination, catheterization, biopsy, fulguration and foreign body removal. It accepts Jackson Telescopes, permitting work under direct vision in areas difficult of accessibility, such as the upper lobes. The new bronchoscope has a distal inspection port as well as oxygen, suction and anti-fog features. **George P. Pilling & Son Co., 3451 Walnut St., Philadelphia 4, Pa.**

For more details circle #838 on mailing card.

Lamco Deodorizer Is Ton-Toxic

Lamco Sanitizer and Deodorizer is a liquid product which can be sprayed or used for damp-mopping to sanitize and remove odors. It prevents growth of molds, eliminates odor creating organisms and kills objectionable odors promptly. Lamco is non-inflammable, non-toxic, harmless to skin and leaves no residue, according to the manufacturer. It leaves no stain or mark on paint, wallpaper, furniture or fabrics and leaves room air pleasant and refreshing after use. Lamco is designed for use in patient rooms, bathrooms, kitchens, laundries, in garbage handling areas and wherever there is an odor problem. **Lamco Chemical Co., Inc., 33 Commercial Wharf, Boston 10, Mass.**

For more details circle #839 on mailing card.

(Continued on page 192)

"Breathing" Bandage in Aerosol Container

Tyrothricin is incorporated in the new Schuco Antibiotic Spray-Band. The "breathing" spray bandage in the push-button aerosol container is non-occlusive and is designed for use in treating burns, abrasions, lacerations and minor cuts. **Schuco Industries, 75 Cliff, New York 38.**

For more details circle #840 on mailing card.

Stainless Steel Needles Are Made in England

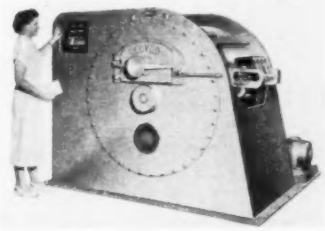
Miltex Stainless Steel Surgical Needles developed in England are now available in the United States. The needles combine the resilience and tensile strength of carbon steel with the corrosion-resistance of stainless steel. Moderate in price, the Miltex Needles are available in the most-used patterns and sizes and are packaged in one-half dozen lots in heat-sealed, double-thick plastic envelopes. **E. Miltenberg, Inc., 43 Great Jones, New York 12.**

For more details circle #841 on mailing card.

Automatic Washer-Extractor Handles 200-Pound Load

A new 200-pound capacity machine has been added to the Glover line of automatic washer-extractors. The new model is fully automatic and washes, rinses, starches and extracts. It is capable of producing up to 300 pounds of clean laundry an hour, yet occupies only 74 by 94 inches of floor space.

The unit is equipped with the Glover Auto-Trol for pre-setting of washing, rinsing and extracting cycle, with automatic water level controls, and the Glover Auto-Feeder which premixes and supplies the correct ingredients at each cycle. It is constructed of heavy steel plate with the skirt, front and shell lined with stainless steel. The two-



pocket type cylinder is stainless steel throughout. **Bill Glover, Inc., 5204 Truman Rd., Kansas City 27, Mo.**

For more details circle #842 on mailing card.

WHAT'S NEW

Pharmaceuticals

Harmonyl

Harmonyl is a new tranquilizing, antihypertensive agent combining the potency of reserpine with fewer and milder side effects. It is a new alkaloid of Rauwolfia canescens and is designed for tranquilizing disturbed or over-aggressive patients, ranging from ambulatory patients with mild anxiety tension to severely hyperactive psychotics in institutions. It is also described as effective in the management of mild essential hypertension and as a supplement to more potent agents in more severe cases. **Abbott Laboratories, North Chicago, Ill.**

For more details circle #843 on mailing card.

Pathibamate

Pathibamate is a combination of Meprobamate, the tranquilizer-muscle relaxant, and Pathilon, the anticholinergic of low toxicity and high effectiveness, to control disorders of the digestive tract and the associated emotional overlay without danger of barbituate loginess, hangover or habituation. Pathibamate is supplied in bottles of 100 and 1,000 tablets. **Lederle Laboratories, Pearl River, N.Y.**

For more details circle #844 on mailing card.

Thixokon

Thixokon is a new urethrographic medium of thickened sodium acetrizoate solution 50 per cent. It is said to have the advantages of optimum viscosity, ideal radiopacity and miscibility with water, blood and urine, and its safety permits urethrography in a greater number of cases. **Mallinckrodt Chemical Works, Mallinckrodt St., St. Louis 7, Mo.**

For more details circle #845 on mailing card.

Literature and Services

• The **1957 Hospital Drug Reference** is now available from McKesson & Robbins, Inc., 155 E. 44th St., New York 17. Prepared especially for hospitals, the reference is a complete pharmaceutical and drug buying guide with cross reference with official and generic names. The book is divided into three sections, product index, manufacturer index and therapeutic index and has a special added section with convenient weights and measure charts.

For more details circle #846 on mailing card.

• Architects and building committee members will be interested in the new 20-page manual released by Penn Metal Company, Inc., P. O. Box 1460, Parkersburg, W. Va. on **Penmetal Partition Systems.** Seven different partition systems for various uses are described and illustrated with information on sound transmission loss, fire resistive ratings and erection and material specifications for each partition. Included are tables detailing required spacing of supports.

For more details circle #847 on mailing card.

• How institutions can stay in operation when power fails or disaster strikes is discussed in a new booklet, **"Power for Protection,"** available from Caterpillar Tractor Co., Peoria, Ill. **Form No. D721** shows through illustrations and actual installations how the Caterpillar Diesel Electric Sets maintain power whenever an emergency strikes.

For more details circle #848 on mailing card.

• **"Floor Designs"** possible with Tile-Tex flooring are illustrated in color in a new brochure available from The Tile-Tex Div., The Flintkote Co., 1232 McKinley Ave., Chicago Heights, Ill. It contains many design suggestions plus examples of custom-made inserts.

For more details circle #849 on mailing card.

• A new folder showing **Lighting Fixtures, Lanterns and Lamp Standards** designed and fabricated by Meierjohan-Wengler, 1102 W. Ninth St., Cincinnati 3, Ohio is now available. The folder illustrates recent contemporary and traditional designs for institutional use.

For more details circle #850 on mailing card.

• **The 1957 Mills Walls Catalog** describes the complete line of movable metal walls and aluminum partitions manufactured by The Mills Co., 993 Wayside Rd., Cleveland 10, Ohio. The 68-page booklet includes specifications, diagrams, illustrations of typical uses and information on hardware and accessories.

For more details circle #851 on mailing card.

• **Sketch Book No. IV** describing Erie Architectural porcelain enamel has been released by the Erie Enameling Co., 1455 W. 20th St., Erie, Pa. Complete specifications and data on curtain wall and veneer panels are included.

For more details circle #852 on mailing card.

Suppliers' News

A.S.R. Products Corporation is the new corporate name of the firm manufacturing stainless steel surgical blades and dispensers for the hospital field formerly known as **American Safety Razor Corporation.** The new name became effective July 1, 1957 and the firm continues to operate from offices at **380 Madison Avenue, New York 17.**

Ditto, Incorporated, 6800 McCormick Rd., Chicago 45, manufacturer of duplicating machines and supplies, announces the establishment of a factory branch office in **San Diego, Calif. J. J. Johnston, Jr.** is manager of the new office.

Electric-Aire Engineering Corp., manufacturer of quality electric hand and hair dryers, announces consolidation of its sales and executive offices in a new location at **3138 W. Chicago Ave., Chicago 22.** The move was made to enable the firm to provide more efficient service and space for expanding production.

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July, 1957

Please ask the manufacturers, indicated by the numbers I have circled, to send further literature and information provided there is no charge or obligation.

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dex to Products Advertised—*Continued*

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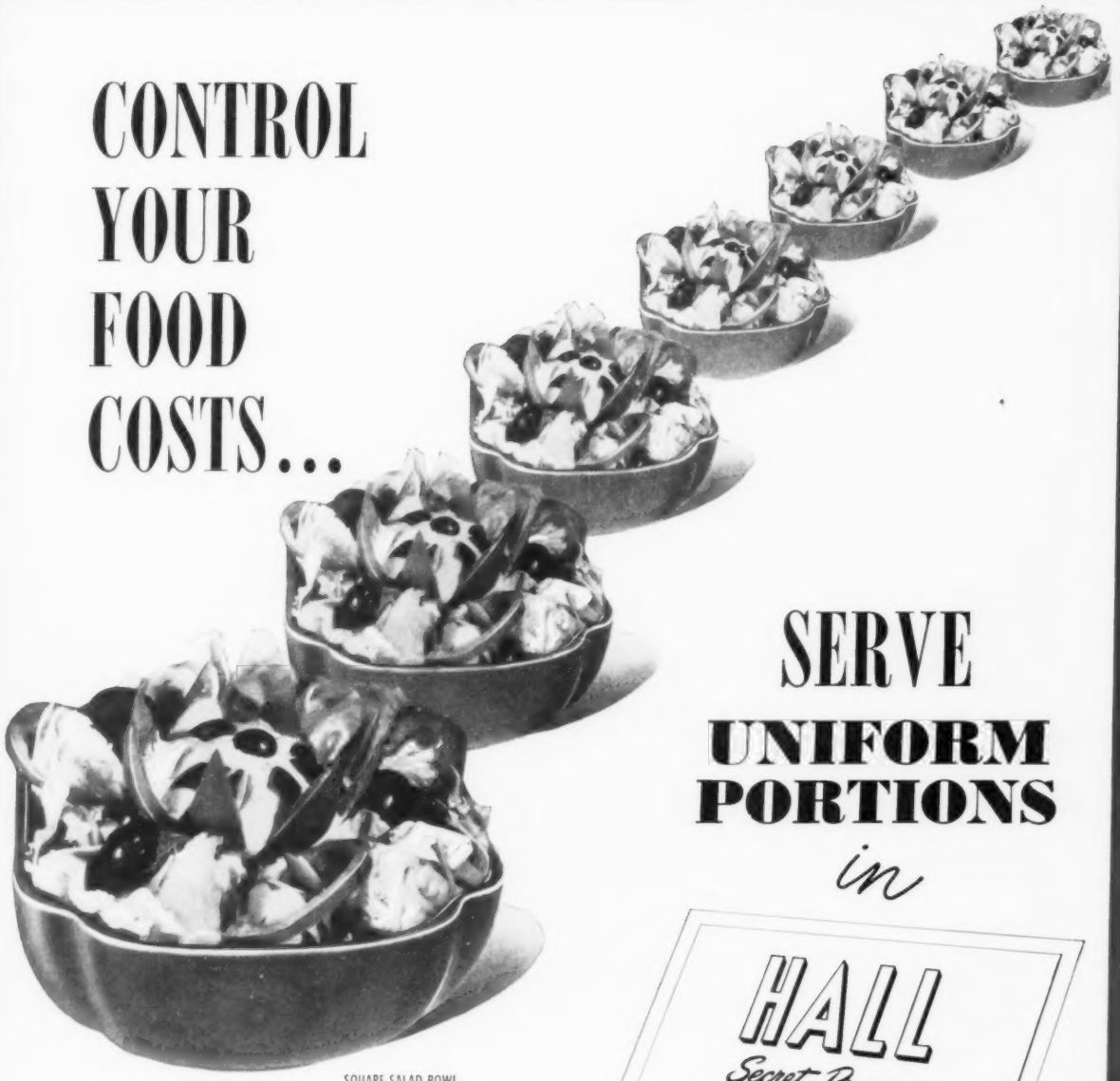

SQUARE SALAD BOWL

SERVE UNIFORM PORTIONS *in*

HALL
Secret Process
FIREPROOF CHINA
AVAILABLE IN 26 BEAUTIFUL COLORS

Hall Salad Dishes, like Hall baking dishes, can be used for automatic control of portions. The capacity of the ware assures uniform servings. Hall Salads are impervious to acids in food and condiments; extremely resistant to scratching or marring; will not pit or corrode—look like new after long service. Write for Bulletin SM-1.

THE HALL CHINA COMPANY • EAST LIVERPOOL, OHIO
The World's Largest Manufacturer of Fireproof Cooking China

AN ADDED SECRET
TO THE SECRET PROCESS

HALL CHINA METAL-CLAD ...by **PLATECRAFT**®

Secret Process **HALL CHINA** plated with lustrous nickel-chrome by a secret process.

Write for Bulletin MC-65

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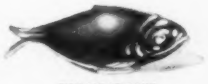

FISH SALAD BOWL

SALAD

SCALLOPED SALAD BOWL

H-12

Unequalled for Special* Surgery:

'CREST' Brown Milled Surgeons' Gloves by SEAMLESS

EZON
Modified Starch
DUSTING POWDER
MICRO-PULVERIZED
APPROX. 1½ GRAMS
by SEAMLESS

UNMATCHED FOR EYE, brain, cardiac and vascular surgery.

THE ULTIMATE IN SENSITIVITY and comfort—47 per cent thinner and softer than ordinary surgical gloves.

NON-SKID SURFACE affords more positive handling when wet.

HYPOALLERGENIC PROPERTIES broaden utility to O.R. personnel.

**NOTE:* Not recommended for general surgery because they are so extremely thin.*

Dust with **'EZON'** the superior, non-inflammatory, rubber lubricating powder for all surgical gloves.

SURGICAL RUBBER DIVISION

THE SEAMLESS RUBBER COMPANY
NEW HAVEN 3, CONN., U.S.A.